The Role of the Teacher in a General Hospital

Thesis

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The Role of the Teacher in a General Hospital

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Abstract

A short history is presented of the work of committees and individuals who have been interested in the teaching of children in hospital. The importance of the normality of education for the life of the child in hospital emerges as a common factor of their beliefs.

The opposing views of two headmistresses on how education should be provided are presented. The first view is that education for children in hospital means the provision of individual tuition for long-stay pupils. The second view is that all children should be taught in hospital and implies that there should be permanent teachers on hospital wards.

Since the teacher works on a hospital ward among other professionals, her role on the ward is discussed. Negotiation is seen to be an important concept.

After a review of recent educational research where studies were undertaken in the classroom, four possible roles for the hospital teacher are defined. Thirty teachers from many parts of Britain were interviewed by a questionnaire/discussion method dealing with many aspects of their role. The answers are compared with Fassam's answers whenever possible.

Volunteers helped carry out a non-participant observation study on four wards of four general hospitals in Britain during school hours. Following this a comparative study was undertaken on two wards of an American hospital. The studies shewed that when teachers were present to work with all the children, the children were engaged in positive activities.

The educational value of the activities is then discussed with reference to the writings of Jean Piaget, means of assessment in normal schools and recent reports from H.M.I.'s.

The conclusion of the study is that the provision of a permanent teacher, even if part-time, means that all children benefit from a near normal work oriented atmosphere. The teacher, with the help of parents and volunteers, can include all of the children in a stimulating atmosphere and help to achieve their return to school with the minimum of disruption.

Contents

List of Figures

List of Tables

Aim

The study was undertaken from 1981 - 1985 in order to help clarify the role of a schoolteacher in a general hospital. The researcher had been a part-time hospital teacher for 12 years and had visited 25 hospitals in Britain and a similar number in the U.S.A. Until 1982, when Fassam published a short account of a national survey she had conducted from the Thomas Coram Institute with the help of 15 fieldworkers who were members of N.A.W.C.H. (The National Association for the Welfare of Children in Hospital), little was known about the provision of education for children in hospital. The survey shewed the lack of available information including even basic statistics, the confusion of opinion on aims and the non-existence of a national policy. Despite this lack of information, policy decisions were being made by education authorities faced with the need to make expenditure cuts in educational provision. It seemed important for this reason to try and make the work of hospital teachers better understood.

It was generally recognised that in the past 25 years since the Platt Report was published and recommended the teaching in hospital of all children, many changes had occurred in patterns of disease, treatments in hospital, nurse training and the practice of education. It was also recognised that children who entered hospital even for a short visit were under stress and provision should be made for their needs. The question at issue was whether the average length of stay of children in hospital was now so short that a permanent teacher was no longer necessary. One view regarded such an appointment as unnecessary and it was argued that where a small number of children were hospitalised for a long time that they could be taught more efficiently and at less expense by

appointing a visiting tutor. For their play needs a therapist or even a volunteer could be provided.

Visits to fellow teachers and discussions with London teachers and others suggested that not all teachers shared this view. On the basis of their practical experience on the wards many believed that there was both an educational and a therapeutic need to be met and that they were in a unique position to meet it. They found that parents were grateful, hospital staff were relieved to see them after school holidays and children found their support invaluable. Nevertheless no firm evidence existed to support this view and to shew that the task they undertook was indeed educational. Thus the aim of the study was to investigate the situation on the wards, to gather evidence of what was happening to the children and to analyse the results in educational terms. It was hypothesised that the employment of teachers on hospital wards would lead to a positive learning experience for the children in hospital.

It is hoped that this study will lead to a better understanding and analysis of the work of the hospital teacher, and it is with this end in view that the study has been written.

Methodology

A non-participant observation study of the activities of children on hospital wards during school hours was considered to be the most appropriate method of research. Recent education and hospital studies had included observation studies of children in their classrooms and wards (Oracle Project, 1975-80[1]; Rutter, M., et al, 1979[2]; Stacey, M.(ed.), 1970[3]; Oswin, M., 1978[4]; Hawthorn, P., 1974[5]) as had K. Sylva in her studies of nursery children.[6] Sylva and others had targeted particular children for study but in this study, as fairly small numbers were anticipated, it would be possible to observe all of the children. By this means it was hoped to record the activities of children on wards both where there were teachers and also when no teacher was employed.

In order to understand what was happening on the wards, a decision was taken to interview a number of teachers. The research had limitations of time and finance. There was no money available for a large scale survey and the researcher intended to continue teaching. As Fassam had found, few statistics were available and the number of children taught in hospital was not known.[7] What was known was that every year 600,000 children of school age were discharged after a stay in hospital. Education in hospitals is provided in two ways. Special schools in hospitals employ 600 mainly full time teachers. If there are less than 25 children taught in a hospital, then groups of children or sometimes individual children are taught by teachers under a special arrangement (Circular 5/74 Department of Education and Science). The number of teachers employed in general hospitals in this way is not known. Fassam conducted her survey with the help of 15 fieldworkers and the resources of the Thomas Coram Institute. Such a survey was therefore not a possibility in

this research and so the decision was made to develop a method of questionnaire and discussion which could be used with individuals or pairs of teachers in their own hospitals. In order to extend the range of teachers geographically both pairs of teachers and a small group of teachers were interviewed at the national conference in Birmingham.

Visits to other hospitals in Britain had led to the conclusion that most British teachers believed in teaching all of the children. Because there was an opportunity to conduct part of the research in the United States where the pattern of teaching was quite different, a comparative study was undertaken on two wards of an American hospital.

The Questionnaire and Discussion

The study was undertaken before the publication of the Fassam account when little was known of the conditions of employment, the previous experience and training or facilities available for the teachers. Two areas were under investigation. First basic data needed to be collected and this could be obtained by means of a questionnaire. Second the intention was to investigate the attitudes of teachers to many aspects of hospital teaching: the role, hospital staff, play curriculum, group and individual teaching, interruptions, rewards, training and other sensitive areas. Four roles were envisaged for the teacher: the normal school role; the situational role (the special role due to the illness of the pupil); the social role due to the teacher working in a hospital not a school; and the 'outspan role', which was concerned with the teacher's contacts outside the hospital i.e. with the schools of the hospital pupils.

The 'normal' school role needed some definition and the recent Oracle studies were examined to see what might be considered normal in 1982.[8] It was hoped that using the findings of these studies would help to ensure an objective assessment of the teachers' responses. It was envisaged that there would be a range of approaches to many subjects such

as remedial teaching, mathematics, art and science and to the use of the computer. It was envisaged that while teachers might use different methods they would be in agreement over their importance. However when questions were asked about the special role due to the illness of the pupil, then teachers were likely to be in disagreement. It was anticipated from talking with teachers that some would feel that hospital studies and writing about the hospital experience were not the concern of the schoolteacher. Also, teachers would disagree as to whether or not they should allow children to play while they were in school. Did teachers spend time counselling parents and children? Questions to do with the social role would be concerned with staff relations within the hospital. The teacher was dependent on the ward staff to have the pupils in the right place at the right time and without their cooperation she could not undertake the task of teaching. The attitude of the teacher to coping with the sometimes complicated situations which could arise due to the unaccustomed presence of parents in school would be investigated. The fourth, the outspan role, where the teacher had an important part to play in helping the child with the continuity of his education from before his entry into hospital until his return to his own school would be investigated. Also included in this role would be the teacher's contacts with local schools.

After considering which topics were likely to be sensitive and need more discussion a questionnaire and subjects for discussion were tried on 5 colleagues who would not take part in the main study. Some questions were rephrased as a result. Despite the pilot study it seems likely that not all the teachers interviewed understood the meaning of 'Social skills' in q. 28. In other respects the design seemed satisfactory.

As the researcher was a practising hospital teacher there were no problems of access, only of availability. 15 teachers were interviewed

singly and in pairs in hospitals in the south of England. The rest were interviewed in pairs and in a group at the conference for hospital teachers in Birmingham in 1982. The teachers, because 15 of them were attending a conference on a Saturday, must be seen as a group particularly concerned with their work.

An attempt was made to ask the questions and initiate the discussion using the same words in the same manner and as objectively as possible on every occasion. This was because the discussion invited expressions of opinion and feelings and sought to probe difficult and sensitive areas. The teachers were of course promised anonymity and their answers were coded by number.

The Ward Study

The purpose of the study was to investigate and compare the activities of children in hospital wards during school hours, when teachers were present and when no teacher was employed. As holiday time was not deemed to be comparable in a child's mind with term time, a hospital ward which had no teacher in term time was used in comparison. Financial considerations limited the choice of hospitals in the study to those of easy access and the study was carried out during school hours on three wards of three different hospitals where there were teachers and on one ward of another hospital where there were no teachers.

The observations did not include recording the emotions of children. There have been many studies by psychologists of children in hospital (Petrillo, M. and Sanger S., 1972[10]; Burton, L.(ed.), 1974;[11] Vernon, D., Foley, J., Sipowicz, R., and Schulman, J., 1965.[12]) and it is a subject of great importance. However it was felt to be outside the scope of this research.

A close look was taken at a number of recent child observation studies both in hospitals and in schools to see what might be appropriate

and possible in the context of the study. Limited time off teaching was granted to the researcher and three volunteers were found to assist. The volunteers had previously worked with the researcher in the hospital and related well to the children; they were not themselves teachers. The observation studies had to be considered in the light of limitations of time, training and experience of those who would carry them out. A simple coding card was devised and piloted. A chart was to be filled in coding each child's activity every 20 minutes throughout school hours and diary notes were to be made describing the activities in more detail.[13] This interval of 20 minutes proved too long as children in hospital were found to change their occupations very frequently. The time interval of 10 minutes proved satisfactory. Four other problems occurred. (1) Sometimes children had more than one occupation i.e. eating and reading; this was resolved by coding what the observer saw as the main occupation and explaining this in the notes. (2) While the original plan was to observe children aged 5 - 16, sometimes 4yr olds were taught by the teachers. As 4yr olds are sometimes admitted to normal schools the decision was taken to include 4yr olds. (3) All the observers had problems with children endeavouring to initiate conversations. The observers were instructed to give the impression politely but firmly that they were not interested. (4) In the case of the code 'sleep', there was a problem in determining whether the child was actually asleep. Again this was explained if, necessary, in the notes.

Permission to undertake the study on the British wards took a considerable period of time to arrange. Permission had to be obtained from the Administration, the Consultants and Nursing Officers as well as the ward staff which included the playleaders. However none of this could be arranged without the active support of the teachers on the wards and in addition the permission of their education authorities. Volunteers and

the researcher had to visit each ward to make arrangements for the study and determine where they could write their notes in the least conspicuous fashion. The plans were successful and children appeared to see the observers as just more visitors.

When parents were present their permission was requested as was that of the older children. All names of children who were in the study have been changed and the nature of their illness has not always been made specific. In practice and without exception, parents were enthusiastic that a study should be undertaken which might lead to the encouragement of the teaching of children in hospital. Children who, for medical or other reasons, were not present for at least 4 of the 10 minutes periods making up a morning or afternoon session were not included in the study. This saved the observers from watching post-operative or very sick children. The intention was to visit each ward for 5 separate days at intervals of at least a week, and when possible on different days of the week although a limitation was imposed by one ward sister who would not have observers on post-operative days. There is no record of the final afternoon on ward B as the observer became ill. The study could not be repeated as during the next 4 days the teacher entered hospital herself and the ward was closed for redecoration.

The teachers were in the wards for only a few hours a day and the code card was designed to find out for what proportion of that time the children were engaged in positive activities. Positive activities would include work, workgames, purposeful play and reading. Waiting and cruising about aimlessly or frequently changing occupations or appearing distressed would not count as positive activities. Chatting would be included as a separate activity. Medical treatment, bathing, eating or sleeping would be seen as necessary hospital activities which were neither positive or negative. The coding card also shewed the organiser of

any of the activities of the children (if there was an organiser other than the child). The mobility of the children was recorded to see how the teachers managed to provide the children who were immobile with school or occupations. The observers had few problems with the code cards. In order to train the volunteers, the researcher and the volunteers worked together in making the observations until the researcher was satisfied that they agreed on the coding.

The American Study

Leave of absence was granted to the researcher to broaden the study by observing children on two wards of a teaching hospital in the U.S.A. where the situation for children was quite different. The H.I.C. committee (Human Investigation Committee), the national ethics committee for hospital research, granted permission for the study but on arrival at the hospital a new nurses' ethical committee insisted on the submission of the research proposal. For reasons beyond the control of the researcher permission was not granted for two months which made the completion of the task difficult. However owing to the great kindness and support of the teacher and the child life workers the study was completed in a period of two months.

1. The Questionnaire and Discussion

As the number of teachers interviewed was small (30), the answers to the questionnaire were easily coded on a large sheet of paper. A similar sheet was used for coding the replies given in the discussion. The design of the topics considered in the discussion meant that many factual questions relating to the questionnaire were further probed. Sometimes this was achieved by asking the teachers what they would do in specific circumstances on the ward. Notes were taken during the discussion and a coding scheme of (1) to (5) was used for the responses. Some of the

results were entered into a computer but with the small number of responses it proved quicker to study the patterns by eye.

The coded answers to each of the 4 roles defined for the teacher were then grouped together. Further consideration was then given to what might be considered reasonable and ideal responses to the questions. Although the study had been undertaken before the publication of Fassam's account, some questions were similar and in those cases it was possible to make a comparison.

Table 3:1 - Basic facts concerning employment and conditions.

A comparison of percentaged answers by the 30 teachers with those of Fassam's 85 teachers.

Table 3:2 - Graphical representation of length of stay in hospital.

Table 3:3-3:6 - Tables of responses concerned with the four roles.

In addition, individual answers of special interest are included in the text.

Table 3:7, 3:8 - Courses for hospital teachers.

The purpose of these questions was to explore what teachers thought of as special skills that could usefully be learnt.

Table 3:9 Rewards in Teaching.

The rewards in this type of teaching must be different from normal school teaching because the pupils are always changing. Responses were varied and were noted at the time or immediately after the interview. Most teachers' responses were assigned to more than one category.

2. The Ward Study

At first an attempt was made to develop a very comprehensive code which could be used to categorise language, social participation, type of play or work and behaviour. This coding was used to observe one or two children who were not in the hospital but in their own home environment. It proved difficult to use and the minutiae of detail were not neces-

sarily relevant for the purpose of the thesis. Next a code was developed which was very simple to use and could be entered on a chart every 20 minutes. This seemed more appropriate for summarising the activities of a number of children who might be in different areas of a ward. However in a trial run 20 minutes proved far too long an interval. In practice children were found to change their occupations very frequently when no adult was involved. The coding was changed to being used every 10 minutes and a diary was kept by the Observers which explained in detail what activity was being undertaken. This coding was tried on the wards and found easy to apply.

The Observer would take with her to the ward a code card, a code sheet and paper to write a diary. The sheets checked with reference to the notes yielded the material for the tables 1 - 19.

Tables 4:1-4:4 - Information compared as to illness, length of stay, mobility and age. Wards A, B, C, D.

Teachers gave this information to the Observers except on A where permission was given to ask the nurse in charge. Mobility was assessed by the Observer. A child was classed as immobile if the teacher had to bring work or activities to a child because he could not move. The medical information given to the Observer was classified by a member of the medical profession into the broad categories shewn in table 1. The age classification used was approximately infants, junior/middle and teen-agers and this classification proved to be helpful in the U.S.A. study.

Tables 4:5-4:13 - Activity studies morning and afternoon. Wards A, B, C, D.

Each table shews the number of ten minute time periods spent by children on different activities. Some occupations like sleeping precluded activities and the time spent on these occupations has been subtracted from the total time to calculate the total possible time. Such

occupations include bathing, eating, leaving the ward, crying or having treatment. Chatting is coded as a separate activity but it is coded if a parent is sitting by the bed of a child even if no chatting is actually observed. For this reason time spent chatting to parents should be seen as an indicator of their presence and not necessarily of actual conversation. An extra table 7 is included of ward A in order to analyse who occupied the children when there was no teacher or playleader. The positive activities of the children have been defined as Reading, Working, Work Games and Continuous Games. It was not assumed that non-teachers could be precise about 'work' categories and the descriptive diary writing needed to be analysed after the observations. The percentage time positively occupied is gained by adding the reading, working and continuous games time, dividing by the possible time and shewing the answer as a percentage.

Tables 4:14, 4:16 - Comparative tables of positive activities, Wards A, B, C, D.

These two tables compare the time spent in positive activities on the four wards during the morning and afternoon sessions. They shew in addition which adult (if any) initiated the activities.

Tables 4:18, 4:19 - Graphical representations of previous tables.

The findings of tables 4:14, 4:16 are illustrated graphically to make the situation clear.

Tables 4:15, 4:17 - Chat sessions compared Wards A, B, C, D.

As chatting was such a popular activity, the number of chat sessions are calculated separately and the adult involved recorded.

3. The American Study

In the American study an additional category (chat phone) was added as children on ward E could have bedside telephones.

Tables 5:1-5:4 - Information compared as to illness, length of stay, mobility and age. Wards E, F.

Tables 5:5-5:9 - Activity studies morning and afternoon. Wards E, F.

An extra table, 5:7, was included in order to analyse who occupied the children on E as there was no teacher for all the children. On ward F ward grannies sometimes occupied the children and (g) was inserted in the tables. (c.l.w.) was used for child life worker or play therapist.

Tables 5:10, 5:12 - Comparative tables of positive activities. Wards E, F.

These two tables compare the time spent in positive activities on the two wards during morning and afternoon sessions. They shew in addition which adult (if any) initiated the activities.

Tables 5:11, 5:13 - Chat sessions compared. Wards E, F.

Tables 5:14, 5:15 - Graphical representations of tables 5:10, 5:12.

The findings of tables 5:10, 5:12 are illustrated graphically to make the situation clearer.

References

1. Galton, M., and Simon, B.(eds.), 'Progress and performance in the primary classroom', Oracle Project. Routlege and Kegan Paul, (1980).

2. Rutter, M., et al, 'Fifteen thousand hours', London: Open Books, (1979).

3. Stacey, M.(ed.), Dearden, R., Pill, R. and Robinson, D., 'Hospitals, Children and their Families', Routledge and Kegan Paul, (1970).

4. Oswin, M., 'Children living in long-stay hospitals', Heinemann, (1978).

5. Hawthorn, P ., 'Nurse - I want my Mummy', R.C.N. (1974).

6. Sylva, K , Roy, C., and Painter, M., 'Childwatching at Playgroup and Nursery School', Grant McIntyre, (1980).

7. Fassam, M., 'Education for children in hospital', Thomas Coram Institute (unpublished) 1982. Account of research, N.A.W.C.H., (1982).

8. See (1) above.

9. For questionnaire and topics for discussion see appendix 2, p.185.

10. Petrillo, M. and Sanger, S., 'Emotional Care of Hospitalised Children' Philadelphia: J. B. Lippincott, (1972).

11. Burton, L.(ed.), 'Care of the child facing death', Routledge and Kegan Paul, (1974).

12. Vernon, D., Foley, J., Sipowicz, R. and Schulman, J., 'The Psychological Responses of Children to Hospitalisation and Illness', Springfield: Thomas, (1965).

13. For code cards and charts see appendix 3, p.191.

Chapter 1

Hospital Schoolteachers: How Did They Get There?

In May 1983 a special feature appeared in the Times Educational Supplement. Susan Thomas, a Times Educational Supplement reporter, had been to visit Guy's Hospital School. All children in the hospital, including visitors, attended this school and on this occasion they were having an Arab day.

> By afternoon the paediatric gym had become an Arab market. Berobed customers shopped at the fruit and sweetmeat stalls, drank hot mint tea or made their own pottery, jewellery and hats. It was first-class education and the only thing missing was a camel.[1]

The quality of 'aliveness' was self-evident but the reporter had this to say:

> Sadly it represents a rare standard of excellence. For in spite of the reports by Bowlby, Platt, Warnock and above all the National Association for the Welfare of Children in Hospital (N.A.W.C.H.), the average in hospital education is inadequate and the worst is non-existent.[2]

There are many who are surprised at there being any teachers at all in our hospitals. How did they come to be there and what do they do when they are there? Was the journalist correct in her estimation of the education at Guy's?

Before 1865 children were very seldom admitted to a hospital of any sort. Dr. George Armstrong, founder of the first children's dispensary in 1769 wrote: "Children, while in their infancy, especially if the young family is numerous and the parents in straitened circumstances, are not thought of sufficient consequence to be much attended to, unless some sudden or violent illness happens to give alarm." He refused to support a proposal for a children's hospital saying, "It very seldom happens that a mother can conveniently go into hospital to attend to her sick child." To him it was axiomatic that mother and child should not be separated.

However, in the nineteenth century, Lord Shaftesbury and Charles Kingsley exercised considerable influence on public opinion. The situation began to change rapidly. In May 1859 at a public meeting in Edinburgh the Revd. Dean Ramsay moved that a hospital for sick children be founded in the city. In February 1860 the hospital was opened. Between 1865 and 1875 a children's hospital was founded on average every six months in England and Wales.[3] The diseases of the period meant that children might be hospitalized for long periods. Voluntary teachers, such as the wives of surgeons in a London hospital, are known to have undertaken to teach children to read.[4]

The first time a hospital school was to be recognised by the Board of Education was in 1912.[5] It was established in the Lord Mayor Treloar Hospital at Alton and was started on the initiative of Sir Henry Gauvain when the hospital was opened in 1908. There were schools in hospitals before this date; in the Liverpool Country Hospital for children at Heswall for example teachers came in from nearby West Kirby Convalescent home where a teacher had been appointed as early as 1900.[6]

The 1944 Education Act recognised the variety of work being done in hospitals by teachers and empowered Education Authorities to provide education 'other than at school', which meant the provision of Home Teachers and Teachers in Hospitals where the numbers or needs did not make the provision of a school a practical possibility.[7] The 1946 Health Service Act enabled Hospital Authorities to make arrangements with Education Departments for the provision of education, particularly for the benefit of long-stay children. The financing of such arrangements was clearly defined and education departments were made fully responsible for teachers' salaries, books and equipment. A circular written at the same time was sent by the Ministry of Education to the Hospitals. It offered guidance on a number of questions and referred to special problems of

teaching in hospitals. "Successful arrangements should nevertheless result in the acceptance of education as an integral part of the life of the hospital."[8]

The birth of the National Health Service in 1948 resulted in the admission of more children to hospital. James Robertson was at work campaigning for the presence of mothers with their young children. The Central Health Services Council set up under the National Health Act was pressurised by a wide range of professional and voluntary bodies to set up a committee under Sir Harry Platt, President of the Royal College of Surgeons, to make a special study of the arrangements in hospital for the welfare of ill children, as distinct from their medical and nursing treatment. In 1959 the Report was published.[9] It said that greater attention needed to be paid to the emotional and mental needs of children in hospital. "The guiding principle which emerges for the care of children in hospital is that while the child must, of course, undergo the necessary investigations and treatment for the condition from which he is suffering, he should be subjected to the least possible disturbance of the routines to which he is accustomed".[10] Part of that normal routine was school. "The provision of education facilities is important, for short-stay as well as long-stay patients, and it is the hospital's responsibility to approach the local education authority for the purpose...teaching requires the co-operation of the hospital staff, suitable arrangements of the ward and the provision of space for storage of equipment".[11] Here in the Platt Report was spelt out a connection between the emotional and mental needs of a child and the normality produced by employing a teacher. Indeed teachers were recommended to take account of the special needs of children arising from the fact of their illness. The committee wished to see special training for such a role.[12]

While there was some improvement in provision for play for children in hospital and more parents were able to stay with their children, the Ministry of Health made no attempt to put into effect the recommendations on improved training for doctors, nurses and other staff. In many respects this humane report, whose committee received a variety of expert witnesses, was gravely neglected. Certainly, no courses were instituted for teachers. Eleven years after its publication, Robertson reflected that some of those most resistant to reform had been eminent paediatricians and teaching hospitals. He also stated that the Royal College of Nurses "fails to recognise that by reason of their immaturity young children are distinctive and vulnerable, and that the quality of early experience affects their later social and emotional development".[13] Perhaps any sudden change was not to be expected considering the submission by the Association of British Paediatric nurses (specialist children's nurses). It included the statement that "emotional responses of a child should be noted by the Ward Sister and unfavourable reactions investigated by the Lady Almoner. These reactions may be due to unsettled home conditions...".[14] Robertson had earlier said, "We may have to wait for a change of generations before the Report is fully implemented".[15] Sadly, it is still not fully implemented.

Meanwhile despite the apparent failure of the Platt Report to cause any radical change within the hospitals, two important initiatives outside the hospitals occurred in the sixties. The Nuffield Foundation had been considering the architectural planning of children's wards and had decided that they needed to be planned quite differently from adult wards; children in hospitals should not be treated as mini-adults. They wrote in their report: "Even for quite old children, the disconcerting strangeness of hospital nursing and the other kinds of treatment becomes much more bearable if the ordinary happenings of the day or night -

meals, toilet, playing and doing lessons, falling asleep - go on in surroundings of a familiar kind, reminding the child, if not of home, at least of school."[16] Obviously, architectural design will not of itself improve the situation for children, but as gloomy Victorian schools have been replaced by bright sympathetic surroundings, so children have become used to a more stimulating environment at least in their Junior and Middle schools.

Even more fortunately a group of those who stood to gain most by any implementation of the proposals of Platt came together to form a very powerful pressure group. These were the parents of the children in hospital.

The National Association for the Welfare of Children in Hospital was set up in Battersea in 1961, with the intent of seeing that young children in hospital should have a regular and continuing contact with their parents - the same axiom that Dr. George Armstrong had propounded nearly 200 years earlier. The society grew rapidly and came to have a large international influence pressurising hospitals and campaigning for separate children's wards, open visiting and facilities for play. After years of campaigning by N.A.W.C.H., the Department of Health and Social Security called together an Expert group to advise on 'Play in Hospital'.[17] In July 1976 the group released their report. It recommended one playworker for eight to ten children, but initially one for each ward. Unfortunately when the D.H.S.S. published the report, a two-page circular was attached explaining that the report's proposals could not be implemented because of lack of finance.[18] As The Times reporter commented, it would have been better merely to approve the recommendation in principle. The report had proposed a new profession of 'Playworker'. The circular said that a senior nurse should be designated as having responsibility for play. The initiatives on play would once again remain in the hands of a nurse who

might or might not be interested. This was a set back, but the society and its influence were growing. Consultants, Nurses, Social Workers, Teachers and Parents joined the association and successive Ministers were willing to listen. The influence of N.A.W.C.H. spread to the U.S.A. and the Association for Care of Children in Hospital (A.C.C.H.) was formed, which holds a large annual conference attended by many health personnel but few teachers. Many teachers in the U.S.A. have been very isolated in their hospitals.

The Chronically Sick and Disabled Persons Act of 1970 and the re-organisation of the National Health Service in 1974 caused public and parliamentary pressure to be put on the Education and Health Secretaries of State to set up committees to review the needs in health care of children who were sick or disabled. The Court Committee reaffirmed the principles of Platt. They wanted children to be placed together in hospital and have special paediatric services. The Report concluded:

> ....whilst much progress has been made in some hospitals, a great deal of evidence was received underlining that it is in the sphere of social understanding of their needs that children are least well cared for. Whilst this is particularly true of the long-stay hospitals our visits made it clear that the personal needs of children in acute hospitals were not always being met. Most of the staff are well aware of the difficulties, but tried to see them in terms of financial and manpower restraints. It is true that the current economic situation does place limits on what can be achieved but at the same time we think it is important to recognise that whatever the financial position, progress will continue to depend most of all on the interest and initiative of those working within the individual hospital.[20]

This comment was made 17 years after the Platt Report.

Although the Warnock Committee[21] was primarily interested in disabled children and their transfer whenever possible to mainstream education, it emphasised once again that all children in hospital should receive education as soon as possible, that rooms should be set aside for educational purposes and that there should be no lower age limit for pupils. However,

reports are not legislation and the recommendations as they apply to general hospitals were largely ignored.

Possibly because there were so few teachers employed in hospitals and so many of those who were employed worked only part-time, the education authorities did not concern themselves with what they were doing. If hospitals asked for teachers, education authorities provided them and possibly some capitation allowance. Few were visited by advisers and most were fortunate if they were given any introduction to anyone in the hospital when they started. Unqualified teachers were sometimes appointed. On the other hand there were some large hospital schools with well qualified staff. Where teachers had been influenced by current educational thinking, schools or wards could be exciting places. A Manchester hospital had its own television studio for children and programmes made by children could be viewed on every ward.

This variation in teaching provison continued. The education authorities kept statistics for only one day of the year and that in January, when all children in school in hospital were registered. This statistic was of little help in determining the total number of children who might be taught in a year and it did not distinguish between types of hospital e.g. general hospitals, children's hospitals or psychiatric hospitals. However it was known that 600,000 children a year were discharged after spending at least one night in hospital. In 1971 all hospital schools became the responsibility of the Education Authority instead of the Health Authority; until then although the Education Authority had provided the teachers, it had been the responsibility of the Health Authorities to request the provision. As a result of this change, the National Association of Head Teachers Special Advisory Committee made a study of the situation and embodied their findings in a report.[22] In the foreword, C.S. Holton, Chairman of the Association, talked of the "Cinderella

branch of Special Education" and noted "the glaring anomalies that exist". A questionnaire had been sent to local authorities and in their replies the authorities did not even distinguish between schools and units with a single teacher. However when there were teachers nearly all of them put all children on the register as soon as they were medically well enough. But the age range of the children placed on the register was very variable. The total number of teachers employed by the authorities to work in hospitals was not known. It was recommended that the school should be in charge of education and play in school hours and the importance of co-operation with hospital authorities was stressed. One outcome of the report was the formation of an association for hospital teachers which meets anually in Birmingham.

James Robertson had suggested that the implementation of Platt might take a generation. Twenty years later in a series of reports on the National Health Service, the Consumers Association checked on the "Welfare of Children in Hospital". They interviewed children, parents and selected hospital staff on representative hospital wards. A sample of twelve children was studied in depth by a child psychologist. He found, as might have been expected, that staying in hospital was traumatic; loneliness was a major factor and boredom was the biggest bugbear. The break with home was particularly distressing. As for teachers the report of a special committee found that education had an indispensable contribution to make in helping children because of its very normality, so underlining what had been said in the Platt report. There had certainly been great improvement in 20 years but not in all hospitals. One third of hospitals had no teaching provision. There was a lot of variation. In the attitudes of trained paediatric staff there had been a marked change but many of the general staff were still not aware of children's non-medical needs.[23] There had been progress, but it was by no means uniform.

No national survey of hospital teaching had been undertaken except for the questionnaire sent out by the National Association of Head Teachers in 1976. An assistant education officer when questioned said: "Present arrangements are minimal, fragmented, ad hoc and the outcome of random historical evolution tempered by neglect."[24] N.A.W.C.H. was concerned for the interests of children and commissioned a report by the Thomas Coram Institute. Members of the London Association of Hospital and Home Teachers were on the N.A.W.C.H. Education Committee to act as an advisory group. The report when published was to be used as a basis for discussion and hopefully to lead to improvements in line with Platt and Warnock. This time a variety of methods was used. 85 teachers, 203 ward sisters, 56 families and 31 children were interviewed. A postal questionnaire was sent to Local Education Authorities and hospital administrators. Meg Fassam, in charge of the research, hoped that by using a variety of techniques a more valid picture of education in hospitals would emerge.[25]

Before the publication of the account of the research project, L.E.A.s were unaware of the level of provision outside their own counties. It was not a matter of overwhelming concern because hospital teachers represented only 0.02% of the teacher workforce. Two H.M.I.s (School Inspectors) had been at work collecting evidence, but they had not published the results. The only comparable evidence lay in the answers to the questionnaire sent out by the association of head teachers. Fassam confirmed the same substantial variation in provision. For England as a whole, on average 48.2% of hospitals which admit children had no teacher, 26% had a part-time teacher only and 25.8% had at least one full-time teacher available. Length of stay before children were taught varied between hospitals and nearly half the admissions were at short notice. Interestingly, most hospitals without a teacher had no

playleader either, and even when hospitals had a playleader there was just one to a hospital instead of one to each ward as recommended by the N.A.W.C.H. Report. Two thirds of wards with no playleader also restricted visiting.

Ward Sisters were questioned and only 53.2% thought that teaching was necessary, but it is possible that all the figures relating to ward sisters should be seen in terms of their understanding of child development. Had they taken the R.S.C.N. certificate? Had they ever had a teacher in their ward? Fassam states that only half of the sample of 203 sisters from 54 hospitals had a teacher who visited the ward but almost all those that did wished to retain her services.[26] Fifty-six families from four hospitals were interviewed[27] and the majority thought education would prevent the child falling behind and twenty-seven mentioned keeping the child occupied. Ten parents mentioned 'mental stimulation' and one or two 'normality'. "If your mind is active but you've got something wrong with your leg, then if you're just sitting there you think about it all the time. But if you've got a teacher saying 'Now I want you to get on with that', you're carrying on your life just as normal and I think this is what is so excellent with education in hospital."

By 1982 when the report was published teaching in hospitals was being cut back.

> In a third of L.E.A.s, spending cuts are pushing an already vulnerable service over the edge: teaching limited only to children in hospital for more than a week, some say two; teaching vacancies frozen; teaching hours reduced; equipment hard to get. This survey shows that if the debate does not start now, there will be no service to reform.[28]

It is ironic that the handover of responsibility to L.E.A.'S in 1971 should have led to cuts which might not have occurred if under the Health Authority nurses and doctors had come to value the teachers.

This report highlighted the difficulties encountered by teachers, often working in isolation and faced with pupils of all ages, in some-

times chaotic conditions. Teachers themselves had written little about their work and only a few articles had appeard in journals. Mostly these had presented descriptions of their hospitals which paralleled the situation at Guy's. There were however two teachers, both headmistresses of many years standing whose publicly stated views on the philosophy of hospital teaching seemed to represent the two different views of those in the hospitals who were concerned with the education of children. Eva Noble of the Royal National Orthopaedic Hospital at Stanmore felt strongly that the teacher must be concerned with the necessity of helping the child grow back into the normality of school. In the British Journal of Hospital Medicine[29] she insisted that play for children in hospital must be an integral part of the hospital school and that some children, even those doing quite advanced work, need play before they are ready for more formal education. She also saw the teacher as the link-person between the outside world of normality and the inside world of family, treatment and illness. She regarded the hospital environment as a very appropriate and stimulating source of education. "The relief of anxiety," she wrote,

> is probably one of the greatest contributions that the hospital school can make to both long and short-term pupils.....By setting up a school-ward situation in which it is taken for granted that everyone works, an atmosphere of purpose and busyness is created which is psychologically, educationally and physically beneficial.[30]

In 1974 she opened a discussion arranged by the Play in Hospital Liaison Committee in which she went further and mentioned that she made no distinction between play and education. She found it very difficult to define a point at which play and learning could be separated. What began as play became conventional learning. Children needed the approach of play and the structure of controlled learning.[31]

In March 1980 Mabel Schulen, who had been headmistress of Great Ormond Street Hospital School for forty years until 1979, gave a talk to the hospital teachers of the Inner London Education Authority on "The Philosophy of Hospital Teaching".[32] Her belief in the importance of normality to the hospitalised child meant "carrying on with the child's own school work as far as it is able - in the way it would be doing": this meant in practice teaching the child probably individually for about half an hour a day with no interruptions from the hospital side and in the organised absence of parents.

> As I see it, folk other than teachers can keep children occupied and happy - nursery nurses and playleaders - but it is the teacher, alone, who can provide what is needed for educational growth.

She admits that the pressure of the ever-increasing numbers of short-stay children in the hospital creates a problem but quotes a mother from the Midlands whose child had been transferred to Great Ormond Street:

> There was a teacher at the other hospital but she was so busy coping with all the children - doing everything and anything - she never had time to get down really to teaching him. She was such a nice person, but she seemed to be a general dogs-body.

Thus her findings were that normality for a child in terms of school meant that learning was taking place and to achieve this a one-to-one private appointment system was maintained.

From my personal experience of 25 American hospitals, this view was upheld by the majority of American teachers who had never considered group teaching. The teachers were seldom free as they were in England to develop their own styles of teaching. This narrow approach meant that those hospitals which attempted to care for the total needs of the child were forced to employ highly qualified playleaders, mostly of graduate status, to cater for those needs. Children in an advanced society were quite unused to being left on their own to cope with the hazards of life. Psychiatrists were prepared to write treatises on the "emotional needs of

the hospitalised child" and the dedicated members of the A.C.C.H. encouraged degree courses consisting partly of teacher training and partly of hospital based learning, to fill the gap. This was an impressive approach to the care of children in hospital but it was also expensive.

In England many teachers, on their own were tackling the problem from the grass roots. Eva Noble had been speaking out of her experience of an orthopaedic hospital where nearly all of the children were long-stay and many were bed-bound. Mabel Schulen was writing from her experience in a specialist Children's hospital. In a general hospital, long-stay children and short-stay children will be found together on a ward. A teacher who walks into any children's ward in term time is immediately faced with a dilemma. Because she is a teacher all children seem legitimately to be her province. If she is experienced she knows that she could interest and make happier nearly all the children on that ward. But here lies the dilemma: among the children there may be one or two whose needs are for concentrated individual teaching. These children may have been making repeated visits to the hospital and the continuation of teaching there has been vital to their ability to return normally to their own schools. Also there may be one or two children hospitalized over a long period. The majority however will be patients whose stay is very short. In this situation the teacher who may have received little guidance must decide what to do. Fassam found that the teachers had not all chosen the same solution and some felt it to be an impossible task to teach all the children.[33] N.A.W.C.H. presented the results of their study to an impressive number of administrators, including representatives from the D.E.S., D.H.S.S. and 25 L.E.A.s, at Cambridge in October 1982. It was a time of educational cuts and it seems likely that the Report's picture of how little was provided by some authorities proved to be not so much a

stimulus for them to do more as a justification for other authorities to economise by doing less.

Nevertheless, the response of N.A.W.C.H. itself was to issue a strong policy report about the role of teachers. It saw them as making a valuable contribution

> -by offering stimulation and a recognisable link with the child's normal life
> -in helping to reduce the child's stress
> -by enhancing and explaining the hospital event
> -in helping the child to maintain academic progress.[34]

Its vision was of an integrated paediatric team, with all staff and parents co-operating for the welfare of children in hospital. It was the same view as had been proposed in the Platt and Warnock reports.

Following the conference, on 31st March 1983 the London Association of Hospital and Home Teachers met with members of N.A.W.C.H. as part of the Kingston Polytechnic 'Learning Difficulties Project' and produced the Kingston Papers[35] which were designed to promote discussion and lead to action in the provision of education for children at home and in hospital. They referred to four main areas of concern: First the role of the teacher; second the basic standards and conditions of work; third the identification of a good code of practice for interdisciplinary co-operation and fourth the selection and training of teachers. They listed 9 roles for the teacher: educator, personal counsellor, friend, liaison officer, career educator, diagnostician, administrator, play therapist, and inter-disciplinary team member. There were quotations from circular 312, the pamphlet produced in 1956 by the Ministry of Education. On the first page there was a statement of belief.

> Living in hospital is like being transported to a strange land, an alien world. Many of the normal 'markers' are missing so the hospital curriculum must provide the child with signposts and markers to enable him or her to live more happily in this alien country. The curriculum should provide the child with the opportunity to manipulate and control and feel a sense of independence in opposition to the dependency induced by the

> role of patient and 'sick' child. It should give freedom, opportunity, and the tools with which to explore and help each one to make meanings of these experiences...The teacher needs to provide the secure relaxed atmosphere in which anxiety can be expressed and reassurance given, a stable environment in which attention can be turned from a preoccupation with illness to an interest in learning...All this should contribute not only to school work but to a development of an adequate self-image in the pupil.[36]

The head of Guy's hospital school shared in the writing of these papers which clearly implied a view of teaching children in hospital which was both educational and therapeutic. It included under 'the role' of the hospital and home teacher the statement that "an L.E.A. which prevents children who are in hospital for short periods from receiving education is acting directly against their special needs."[37]

However, those who were employing the teachers did not necessarily share this view. They argued that enormous changes had occurred for children in hospital. The great majority of children, because of control of disease, better treatments and modern anaesthetics, were in hospital for a very short time. Fassam had quoted the D.H.S.S. figures to give the average length of stay in paediatrics as falling from 9.6 days in 1967 to 5.9 days in 1977 (but the concept of average might be misleading as 'average' concealed the fact that a relatively small number of children stayed in hospital for long periods and many others needed repeated admissions).[38] The task of attempting to occupy such a mixed age range of largely short-stay children should not be undertaken by teachers. The need was for therapy and this was the concern of the hospital which could employ Playleaders or Volunteers. The few long-stay children could be given a private tutor who would teach them individually for a few hours each week. The children might actually benefit as they would have a playleader and a private tutor. This was the view of Mabel Schulen.

In 1984 an influential authority concerned with the education of children in hospital said that his concern was not with the needs of

short-stay children but with the assessment and curriculum needs of long-stay and recurrent pupils. If teachers thought there was a need to teach short-stay children the role must be seen to be educational and not pseudo-psychological. The question to be asked was whether short-stay children had been affected in their educational progress. This appeared to be in disagreement with the view put forward at Kingston.

Despite the decisions that were being made by the employers, the local education authorities, no observation studies had been carried out to see how teachers were carrying out the complex task of teaching all the children. While the value of teaching all children in hospital might be open to question the matter should not be decided without evidence. Research was needed into the benefits for short-stay as well as long-stay children when education was available in the hospital. The evidence provided by Susan Thomas as to what was happening in Guy's Hospital was clear. All children were included in a lively school and Eva Noble would have approved. Most American teachers and some in Britain held a different view. Their view was of a tutorial system for the long-stay children and no educational provision for the rest. The observational studies of chapter 4 and 5 will provide evidence of the activities of the children in hospital wards under both systems. Before considering these studies, it is necessary to see how the teacher could fit into the social setting of the ward because this is very different from the social setting of the school.

Summary

Teaching children in hospital began in Britain at the beginning of the 20th century when learning the 3 R's was the foundation of education. The Platt committee in 1959 was one of several committees and individuals

concerned with the welfare of children in hospital to recommend education as providing normality. Education was important because all children go to school and the provision of normal routines would help reduce stress for the children. The setting up of N.A.W.C.H., the National Association for the Welfare of Children in Hospital, in 1961 led to pressure on hospitals for the presence of parents and the introduction of play-leaders. After 1971 the responsibility for employing the teachers in the hospitals belonged to the L.E.A.'s and by 1982 the authorities were having to make spending cuts. The short stay of the children and the supposed difficulty of the task led to education being seen by some as only necessary for the few long-stay children. The rest should be in the care of the playleader or some other therapist. N.A.W.C.H. commissioned the Fassam report on the education of children in hospital, an account of which was published in 1982 which highlighted the variablility of provision and the lack of statistics available. Following the publication of the account N.A.W.C.H. supported the therapeutic view which was that the provision of teachers helped in the reduction of stress and also proposed that teachers could enhance and explain the hospital event. In 1983 the London Association of Hospital and Home Teachers proposed 9 roles for the teacher making it clear that they thought counselling and work of an inter-disciplinary nature part of the teacher's role. The concept was that of the teacher being a member of the ward team, a view shared by N.A.W.C.H.

In 1984, an influential authority on hospital education addressing teachers in London and Birmingham made it clear that it was his opinion that teachers should not be employed in hospitals to help solve the 'pseudo-psychological' problems of short-stay children; if teachers thought this was an educational task, they needed to show that the hospital stay had affected the educational progress of the children. Their

concern should rather be with the needs of the long-stay and recurrent children and in particular with the provision of a proper curriculum.

References

1. Thomas, S., 'Teaching Hospitals', Times Educational Supplement, May 6th, 1983, p.23.

2. Op.cit.(1).

3. Graham, S., 'Little Victims - sick children in the Victorian Era', a Nursing Times Supplement, (1977), pp.7-8.

4. Linthwaite, H.S., 'The changing role of teachers in hospital school', J.I.E. of University of Newcastle, March 1965.

5. McBride, M.T., in 'Children in Hospital', Papers given at a Liverpool conference of the Association for Special Education (Merseyside Branch) in September 1965, p.1.

6. Hay, J.D., in ibid., p.6.

7. Op.cit.(5), p.1.

8. 'Education in Hospitals', National Health Service Memorandum H.M. (56) 81 par. 1.

9. 'The Welfare of Children in Hospital': The Platt Report. H.M.S.O., (1959).

10. Op.cit.(9), p.4.

11. Op.cit.(9), p.39.

12. Op.cit.(9), p.37.

13. Robertson, J., 'Young children in hospital', (1970) (2nd edition), p.116.

14. Op.cit.(13), p.132.

15. Robertson, J., The Times, 18th of February, 1964.

16. Duncum, B.M. (ed.), 'Children in Hospital: Studies in Planning', The Nuffield Foundation, O.U.P., (1963).

17. 'Play for Children in Hospital', D.H.S.S. Report, (1976).

18. 'Play for Children in Hospital', HC(76) 5 D.H.S.S. Circular (1976).

19. 'Fit for the future': The Court Report. H.M.S.O..Cmnd 6684, (1976).

20. Op.cit.(19), p.190.

21. 'Special Educational Needs': The Warnock Report, (1978).

22. 'Hospital Schools in England and Wales', N.A.H.T., (1976).

23. 'Children in Hospital', A Which Campaign Report, May 1980, p.1.

24. Rogers, R., 'Crowther to Warnock', Heinemann (1980), p.44.

25. Fassam, M., 'Education for Children in Hospital', N.A.W.C.H. (1982), p.4.

26. Op.cit.(25), p.13.

27. Op.cit.(25), p.15.

28. Rogers, R., Education Guardian, September 28th 1982.

29. Noble, E., 'The place of the hospital school', British Journal of Hospital Medicine, January, 1972.

30. Op.cit.(29), p.77.

31. Noble, E., 'Working Together: School and Play in the Hospital Scene', National Children's Bureau, June 1974.

32. Schulen, M., 'The philosophy of Hospital Teaching', 65/74.

33. Op.cit.(25), p.3.

34. N.A.W.C.H. Executive Policy Statement, March 5th 1983.

35. 'The Way Forward'. Kingston Conference Papers, (1983).

36. Op.cit.(35), p.1.

37. Op.cit.(34), p.6.

38. Op.cit.(25), p.2.

Chapter 2

The Social Role of the Teacher in the Hospital

The teacher comes out of an educational world, but, as a hospital teacher, she has to operate in the social world of the hospital ward, which is the basic unit of the hospital. Ideas on education both of children and of nurses have changed and technology has advanced; visiting is more widespread. All these matters affect children. Nevertheless the ward remains the fundamental social setting both for the child and for the teacher. Any discussion of the role of the teacher must begin with a consideration of the ward and the place of the teacher within it. While it is easy to imagine a tutor sitting by the individual's bed and helping him with his school work, it is difficult for those who have not visited a children's ward to envisage a teacher working with all the children in this situation. So let us begin by imagining the scene at 9:15 am one morning. On the children's ward the day has already begun. Doctors are making their rounds, nurses are bathing and bedmaking, cleaners are sweeping. The bustle proceeds around mostly silent children. A middle-aged lady pushes a trolley through the ward. On it there is a large red box, a huge roll of paper, some felt pens, books and games.

She stops to talk to the children as she passes by. Unlike the curious doctors the children have seen those red boxes before. They come from the County Museum. What is inside this one? She leaves them to guess. They see the paper and the familiar books. In a few minutes the children will join the lady and the badger will emerge in all its glory. The paper will be in use as will the computer and the other electronic devices of a modern age. As the nurses come to tend the children the badger is admired or criticised. The computer is taken over by the doctors (are they in a hurry?) and the books are put to use. The middle-

aged lady is the teacher and the school day has begun. The children are talking, and even for some of the very sick it is a meaningful event. This is an event but not one that a hospital patient would have anticipated. It is not, after all, a school but a hospital and so the teacher's role in the life of the hospital must be considered in relation to the role of others who are more usually associated with life in a hospital.

A teacher in a hospital is most frequently to be found attached to and working on a children's ward. The ward is part of an institution with its own norms and rules. It is not like school or home although children who enter it from boarding school have frequently acquired helpful social skills. Most parents today have the reasonably recent experience of the maternity hospital. The children cannot be said to have derived much social profit from the same experience! On entering the ward parents and children are anxious. Unless the hospital has many single rooms, the experience is public. The child is almost immediately given a bed and a locker. This is his identifying place and very important to him. This is where his parents come and look for him. In days past he stayed there for weeks on end undressed and feeling ill. Today with modern drugs the experience is shorter. The nurse who admits him and gives him his bed is but one of a sea of strange faces. A few years ago in Children's Hospital, Boston, it was discovered that children were being interviewed by eighty different people on their day of admission. The numbers now will be small, but nevertheless the faces will still be strange.

The schoolchild has previous experience of two institutions, his home and his school. At home his parents direct his behaviour. He has had many years of learning the system. In hospital his parents behave differently. They give him presents and sweets but their faces are grave. They too are strangers in a strange world. The Swansea researchers wrote

> In the ward therefore, the child had to learn the new role of patient which involved coming into contact with two new categories of people formerly outside his experience, namely hospital staff and his fellow patients. The role relationship he had previously had with his parents was also greatly modified by the new situation in which they were interacting so he also had to adjust to that.[1]

One evening after a week in hospital Mark, aged 6, woke up all the other children at 10 pm and made them shriek out. The night nurses became angry and pushed him in his bed to the playroom. The next morning all were complaining about him and he looked most upset. Why did he do it? He told the teacher that at home he and his brothers yelled out every night around 10 o'clock and then Dad would come up for a chat. It was the only way to attract his attention. When the nature of the nurses' work was explained to him, he understood their annoyance and he did not do it again. The child at home knows that his parents are in charge. At school they leave him in another institution with different rules. Certain behaviour is expected of him and his activities are directed and are under supervision for a limited period of the day. The first weeks are a shock because the group must be considered - teacher is not always free to attend to him. Nevertheless it is to teacher he must look for order and authority and initially it is to one teacher. The school child then has experience of two systems. On entering hospital he enters in Goffman's terms 'a total Institution'.[2] He, together with all the other patients, is required to conform to a tightly arranged schedule designed to fulfil the aims of the institution. One of the six propositions on which the Swansea research was based was "The hospital constitutes a qualitatively different system, its most important characteristics perhaps being that it is a relatively closed system located in one place and that it has a formal hierarchical organisation."[3] It is a closed system because those for whom it is designed do not leave it. Unlike school all activities happen there - eating, sleeping, playing. For the teenager

there are similarities with prison - he cannot escape. For the youngest children it is forever; tomorrow may never come.

On paediatric hospital wards nurses are encouraged to be aware of the way in which children experience the ward. An important and popular textbook for children's nurses, which is 1680 pages long, puts a great emphasis on childhood development and the emotional and social aspects of child care.[4] Another writer makes the point forcefully:

> Children are often frightened by anything which is unfamiliar to them - people, uniforms, equipment - and must be helped by the nursing team to overcome these fears. Nearly all children think in an imaginative, magical way and so the nurse must understand this.... If every effort is made to adopt the routine the child follows at home wherever possible, and to take into account food fads and other idiosyncrasies, the child should feel more secure.[5]

When nurses take particular care to help children feel at ease, and most children, as was found at Amersham,[6] do in fact appear to adapt fairly well to the new system.

At the centre of the system there is always a ward sister (or two) to coordinate operations. By long tradition the ward sister in a British hospital is greatly respected and even the doctors heed her expertise. In a study of 26 residential institutions for children findings suggested that "The role of the head of the unit and the way she performs it is extremely important in establishing the pattern of care for her unit."[7] This is indisputable, and means that her attitude to education will be of crucial importance to the teacher.[8] But the ward sister does not operate alone; she is the head of a team and the team has many members each of whom has a part to play in the process of solving the problem of why the patient is ill and then aiding him in the process of recovery. The team is under the direction of the doctor but the doctor does not spend much time on the ward. He examines the child and talks to the parents. He listens to the sister or to the staff nurse in charge and if necessary

consults with the therapists or the medical social worker. His visits may occur at any time and are brief but important.

The doctor makes the decisions but it is the nurses who spend the most time with the child and his family, and it is the nurses who comfort those in distress or shock. Often the care is routine but sometimes the medical social worker has to be called in to offer help both of a practical and a counselling nature, linking outside agencies and community resources as well as working closely within the team. Another member of the team is the physiotherapist who uses her specialised skills to design programmes to stimulate the child to achieve optimum physical functioning. The playleader however is the member of the team whose tasks are most similar to those undertaken by the teacher and her role calls for a rather fuller description.

Playleaders are to be found in 40% of English hospitals that admit children.[9] In the Hospital Playleader Project a study was made of two wards where playleaders were introduced for the first time. The playleaders who were largely unguided had to establish themselves in a hierarchical system already in existence: "As the research progressed it became increasingly obvious that the ability of playleaders to influence children's behaviour was itself powerfully influenced by the nature of the relationships established between the playleaders and the medical, nursing and domestic staff in a ward".[10] Very many British playleaders have a nursery nurse training for children 0-7 years, and yet have to carry out an innovative role with children of all ages. The playleader then starts not very well equipped for the task unless she happens to have been on a special course, and has to convince the nurses that 'Play organisation' is a real job and of great importance. She has to overcome the resistance of the staff to yet more mess. She has to acquire equipment and keep it safe. She has to tread a very difficult path because

nurses tend to see her as a pair of extra hands ever there to help make beds or feed babies. She is usually quite young with little experience. It is not surprising that the role takes quite a long time to master. On top of all this she has to present a smiling face and a listening ear to parents, nurses and children at all times. Once she has established herself she gains authority because "in organisations, authority is power legitimated by the conferment of collective approval."[11] She needs and seeks the positive backing of the ward sister so that she can gain freedom of manoeuvre. The task is much easier for the American Playleaders, who as has been said are often graduates,[12] sometimes with higher degrees and have adequate psychosocial training for the task. They will never be given nursing duties and their opinions will be heeded. Since her role is, in many respects, similar to that of the teacher, it might be suggested that the presence of a playleader is sufficient to meet the needs of all the children including those of school age. Certainly after two years apprenticeship she is a regular and fully established part of the ward team. Nurses and children trust her. She has acquired equipment and established a work pattern. She is now better at relating to teenagers. She herself now understands the system. However there are problems. For example the needs of even one sick distressed toddler are very pressing. Small children are very demanding and they have first call on her attention. So she may have to leave the older children to their own devices. Another problem concerns children who have to be isolated because of infection. Here the dilemma is obvious. Does the playleader shut herself in with the one child and leave the rest or does she with regret abandon the sadly isolated child? The use of volunteers can be a great help in this situation. In the United States many students work in hospitals as part of their undergraduate courses. In addition there are many older volunteers and the 'hospital grandmother' may play a big part in

the life of the ward. Of course there are splendid volunteers in England, but they seem few in number and do not always stay for long. But though they can help, they cannot solve the playleader's dilemma. She is committed to the needs of all the children but in practice must put first the needs of those who are younger and more isolated.

With so large and varied a team it may be thought that the child in hospital will be almost entirely occupied by the attention of the doctors, the nurses, the social workers and the physiotherapists, and that the parents can occupy the intervening moments.

Since nurses are the members of the team who have the most extensive contact with the children during their stay on the ward, it is a matter of some concern to discover from recent nursing studies that the nurse time spent with individual patients is relatively short. Pill found that "the basic nursing which forms the greater part of the nurse's work does not occupy all day. Yet any time over is not spent with the children".[13] In Swansea

> One of the striking findings of the ward studies was the long hours which the child spent unoccupied and alone. This constituted at least half and in some cases up to 80 per cent of the child's waking hours.[14]

If nurse time with children is somewhat limited - in Hawthorne's study[15] an average of 75 minutes per day per child, who else other than the nursing team may be spending time with children? Mention has been made in some studies of the role of ward cleaners in this respect, and during the course of this study ward cleaners were on several occasions found to be occupying children in distress. Ward cleaners and also ward clerks are members of the ward staff who are often to be found attached to one ward alone. It is for instance the ward clerk who may help the children with the telephone but this sort of activity does not occur very frequently. But are not parents the most natural people to whom children should turn? Unfortunately, it must be said that in general there are practical

difficulties for the mother: "It has been recognised that the recommendations for parental involvement have seriously underestimated the mother's home commitments".[16] Problems include transport, mother's job, siblings and their care. Of course the child in hospital is important but the mother feels bewildered like the lady interviewed at home who said

> I've never really thought about it as none of my kids have been in that long. My friend across the way went in to see her little girl with a broken leg. She was down there for hours and didn't know what to do with herself. It's nice to be with them but you're thinking of things to do and your husband's meals and so on.[16a]

It is clear then from the discussion of the roles of the nursing team and the ward staff that there is room for the teacher. However the teacher can only achieve her aims with the goodwill and cooperation of the team and this needs negotiation. Negotiation is fundamental to the life of the hospital. "To consider the effect of the hospital on children without considering the hospital itself as a complex area of negotiation would seem futile."[17] The situation in a hospital is never static. Not only do staff work on shifts but treatments are apt to change. Moreover for reasons of safety or order roles must sometimes be shared. All this calls for negotiation which depends on understanding and reasonableness under possibly highly emotional conditions. Such negotiations, and even conflict, are inescapable. As one survey concludes, these "need not then be viewed as dysfunctional consequences of imperfect management, but the natural stuff from which everyday patterns of relationships are evolved and evolving."[18] All this requires a clear perception of one's own role and the roles of others. This is a 'social skills' task. A most valuable analysis of these skills and a description of how health personnel may be trained in their use is to be found in 'Social Skills and Health',[19] edited by Michael Argyle, a leading authority in this field. There has been a rapid growth of social skills training in

Industry. It is a sophisticated affair and it is to be hoped that one day it could be part of an initiation programme for all trained personnel in hospitals. The training might include role play, videotaping and case discussion. Some of these techniques are already used in the training of social workers and teachers and more recently with nurses. However it is hard to see how such a joint professional skills training could be financed but it would be an excellent idea. Without it the teacher must spend time in negotiation with many individuals.

From her previous experience of the institution of the school, the teacher has learnt how to educate a certain age range of child in the absence of his parents. Authority, recourse to support, equipment, syllabus, mobile children, classrooms are taken for granted. Not so in a hospital. Here even the presence of children in the right place at the right time must be negotiated. Negotiations with the playleader are vital - is equipment to be shared? Are the children to play or work? There are so many areas for disagreement that it is no surprise to find that in a number of hospitals each has adopted a role apart from the other and little communication exists.

Negotiation then is the process by which the teacher must achieve her aims if she is to work successfully in the hospital. Unfortunately while she may have aims that are clear to herself or to her fellow teachers these are not always understood by her colleagues on the hospital staff. While all teachers could be supposed to wish their children to return with as little difficulty as possible to the normality of their own classrooms, the two head teachers whose views were discussed in the first chapter may be taken as representing two quite different methods applied to achieve this aim.[20] Eva Noble believed in the stimulation and purposefulness of the ward school; Mabel Schulen believed in individual tutoring. Whichever method was used the teacher could find herself in

difficulties in practice. If school was for all, nurses with their care plans for the children would need to adapt them to fit in with the teaching programme. Parents would arrive at whatever time suited them and although most believed in school for their children, they would have to consider whether to encourage their children to take part or to remove them at least temporarily for a chat or a walk. If tuition was individual, the tutor might appear only to find her pupil had just left for an Xray or treatment. In addition even if the pupil was present, the tutor might not be told of the child's medical condition or his change of circumstances. For these reasons communication and negotiation are seen to be of the essence of the task.

Since it was known that the views of teachers about their role were far from uniform, interviews were carried out with 30 teachers in order to get a more detailed and representative picture.

Summary

Both teachers and pupils are based on a ward which is part of an institution with its own rules and organisation. Unlike school or home the child cannot leave and so it is a closed institution. The closed nature of the institution implies a need for stimulation to be provided to aid developmental needs. The ward staff are seen as a team working under the authority of the ward sister. There is a place for the teacher as part of the team. Negotiation is seen as essential in carrying out the practice of teaching and 'social skills' training as very helpful in coping with situations that arise on a hospital ward. Parents emotionally involved with problems inside and outside the hospital and playleaders occupied with young children do not appear to be in a position to teach or occupy all the children of school age.

References

1. Stacey,M.(ed.), Dearden,R., Pill,R., and Robinson,D., 'Hospitals, Children and Their Families.' Routledge and Kegan Paul. (1970), p.94.

2. Goffman,E., 'Asylums: Essays on the Social Situation of Mental Patients and Other Inmates', New York. Doubleday. (1961) p. 6 cited in King, R., Raynes, N., and Tizard, J., 'Patterns of Residential Care'. Routledge and Kegan Paul, (1971), p.46.

3. Op.cit.(1), p.90.

4. Whaley, L., and Wong, D.,'Nursing care of infants and children', The C.V. Mosby Company, (1983, 2nd ed.).

5. Matthews,A., 'In Charge of the Ward' Blackwells, (1982), p.87.

6. Op.cit.(1), p.109.

7. King,R., Raynes,N., and Tizard,J., Op.cit.(2), p.197.

8. Fassam,M., 'Education for Children in Hospital', N.A.W.C.H. (1982), p.12.

9. Op.cit.(8), p.14.

10. Hall,D.J., 'Social Relations and Innovation', Routledge and Kegan Paul, (1977), p.3.

11. Op.cit.(10), p.34.

12. Wiles, P., 'Hospitalised Children in the U.S.A.', Journal of Special Education: Forward Trends, Vol. 6, No. 44, Jan. 1980, p.23.

13. Pill, R., 'A Social Study of the Hospitalization of Young Children', Unpublished M.A. Thesis (Swansea, 1967) cited by Hawthorn,P.J., 'Nurse - I want my Mummy', R.C.N. (1974), p.28.

14. Pill, R., 'The Sociological Aspects of the Case-Study Sample' in op.cit.(1), p.157.

15. Op.cit.(13), p.65.

16. Op.cit.(10), p.17.

16a. Ibid.

17. Op.cit.(10), p.34.

18. Hall,D., Pill,R., and Clough,F., 'Notes for a Conceptual Model of Hospital Experiences as an Interactive Process' in Stacey,M.(ed.), 'the Sociology of the NHS' Sociological Review Monograph 22, University of Keele, (1976), p.152.

19. Argyle,M.(ed.), 'Social Skills and Health', Methuen, (1981).

20. See above ch. 1, p.11.

Chapter 3

How do Teachers view their role?

A study of how teachers view their role could have been made in at least three ways: by analysis of articles in newspapers and journals; by observation of teachers in their wards; by use of a questionnaire or the holding of a discussion. The first method seemed too limited. Few articles have been written and most have come from the pens of head teachers. The second method might be preferred but in terms of time and cost was impractical. In addition there was a personal reluctance to intrude on colleagues who were already trying to do a difficult job. A decision was therefore made to use the third method.

In planning the questions to put to teachers it was necessary to view the situation of the teacher in the normal school. An invitation to a Primary Workshop in Oxfordshire in July 1983 run by the Senior Adviser for the County had this to say:

> We will examine the best of contemporary practice in Oxfordshire....among specific topics to be covered will be:
>
> - Organising the classroom environment
> - The basic skills of language, mathematics and science
> - Developing the creativity of children
> - Teaching through topics
> - Involving parents as partners
> - A new definition of the curriculum

It seemed appropriate to consider at least these questions in any discussion with hospital teachers. But one local authority adviser's list of topics would be too narrow a basis to take over without some wider considerations. It was necessary to look at a national view. The ORACLE study, an S.S.R.C. study from 1975-1980 of 58 classes and 58 teachers in 19 primary schools (encompassing 7-12 yr. olds) under 3 L.E.A.'s, set out to see what had happened in schools since Plowden. The study looked at what teachers and children were actually doing in their classrooms. Were

they using discovery methods, probing, exploring, organising projects, suggesting problem solving activities? The Plowden Committee said

> The school sets out deliberately to devise the right environment for children, to allow them to be themselves and to develop in the way and at the pace appropriate for them. It tries to equalise opportunities and to compensate for handicaps. It lays special stress on individual discovery, on first hand experience and on opportunities for creative work.[1]

However the dangers of going too far in this more liberal direction led the Prime Minister Mr. Callaghan in 1976 to call for more attention to Literacy and Numeracy, but the H.M.I. survey 'Primary Education in England' October 1978 sought to allay these fears and said that the real danger lay in too much concentration on the basics![2]

Teachers in England were not used to classroom observers and the Oracle study is one of few to put observers in classrooms to annotate both teaching methods and pupil activity. The results were a surprise. The traditional curriculum persisted. Progressive teaching hardly existed. There was very little pupil-teacher work interaction on a conversational level. There was a low level of problem solving activity and children were frequently to be seen doing boring workcards.[3] "It is exceptional to find a base group cooperating on a scientific problem, constructing a model, writing a play or working on a mathematics project".[4] While these teachers might have given a quite different impression if they had been asked what they did rather than observed in the doing, one can only conclude that the liberal views of Plowden were not dominating teacher's notions.

Hospital teachers had started out in the normal school system but they might have developed more or less liberal views on education. Normality in education outside the hospital was hard to define so that there could be no pre-conceived view of what would be normal in education within the hospital. Before 1982 little information was available as to

who the teachers were, let alone what they did or in which hospitals they were working. The Fassam account[5] has been seen to be the only national study of teachers in hospital and, although it was published after this questionnaire was put to teachers, such is its importance that wherever possible the answers will be compared. The aim of this study was wider than that of Fassam as an attempt was made to elicit the opinions of teachers over a broad spectrum of questions on the practice of teaching and the philosophy of education. Teachers' opinions might well differ from their practice; ideally they should be observed as in the Oracle study,[7] but for financial reasons this was not possible.

A possible approach was suggested by the work of Maureen Pope[8] and others engaged in educational research who were using 'Construct Theory' with teachers in training. Trainee teachers constructed a representational model of how they perceived the teaching activities in which they were involved. This process proved to be of such significance that at the International Congress on Personal Construct Theory in Oxford, Pope averred

> It is my belief that the constructs of teachers and pupils are more important than the 'system' or 'method'... It is surely the constructions of the people within the system that is the real source of influence on any outcome.[9;9a]

The idea of using construct theory itself was therefore an attractive notion, but it would not have been practicable to undertake such a task adequately. Moreover there was a good deal of purely factual information that it was desirable to collect at the same time. A short questionnaire would be useful for obtaining much of this information.

A questionnaire to a representative sample of teachers might be the best method, but would not give very much insight into their feelings. A questionnaire combined with discussion would be more revealing. Answers to the questionnaire would not provide evidence of practice but would

give information on equipment and conditions - basic information which before Fassam had not been researched. A school implies certain minimum standards of these but in a hospital the same standards might not necessarily apply. In hospitals, the teachers have to work on the territory of others and they have to accept the rules of another employer as well as their own. How did they set about teaching basic school subjects in such an environment? It was in the discussion that an attempt would be made to elicit opinions on these and other subjects about which it was hypothesised that they would have differing views. Their teaching practice might not correspond to their opinions but at least the discussion would enlarge upon the answers to the factual questions and would highlight the nature of the problems with which 30 teachers felt they were confronted.

Despite the desire to have a representative sample of teachers it was beyond physical and financial means. Thus two groups of teachers were selected. The first group consisted of 16 teachers interviewed singly and in pairs from 7 hospitals which were easy of access from Oxford (these included London). The second group were more than 14 teachers recruited from those attending the meeting of the National Standing Conference for Hospital Teachers in Birmingham. They came from 13 hospitals all over England and were interviewed in pairs and in a larger group, although some of the papers from the larger group were abandoned as they were not completed. Obviously those attending a teachers' conference were highly motivated and this must be understood as a bias in the responses. All were teachers in general hospitals unlike Fassam's sample. Experience of visiting hospitals led to a conclusion that teachers were most likely to be available at lunchtime, so that the first group of teachers were interviewed in their own hospitals in ones and twos using a structured discussion followed by a questionnaire. The questionnaire took four minutes and the discussion about forty-five minutes.

The Questionnaire and Discussion* were based on a concept of 4 possible roles for a teacher: a normal school role; a situational role; a social role and an 'outspan role'. The first must cover a broad range of possibilities and would include many factual questions. The fourth, 'an outspan role', was meant to include all contacts outside the hospital such as making links with the child's own school, arranging home tuition and visiting mainstream schools. It was with regard to the second and third roles that teachers might have very different opinions. By a situational role was meant a role connected with the illness of the child and his feelings about the hospital. Teachers might or might not feel this was their province. The social role included the role of organising a normal school within a ward system as well as making relationships with ward staff.

The questionnaire was checked against topics considered by the inspectors in a private paper (1981) to be of importance. The questionnaire and discussion topics were tested on six teachers who had varying experiences of hospital teaching but who would not take part in the main study. Their help was solicited and, while the presentation of the questionnaire was radically altered and some of the phraseology clarified, no major change of question or order of question was made.

Fassam's report was not concerned only with teaching in general hospitals. She included Orthopaedic and Children's Hospitals in her sample of 85 teachers in 28 hospitals. In hospitals of that type the average length of stay of children is longer and there is normally a more structured school. The medical condition of the children, however, is much the same as that of some of the children who may be found in general hospitals in other regions. The assumption was therefore made that there

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* See app. 2, p.185 for questionnaire sheets and topics for discussion.

was sufficient overall similarity between the role of the teachers for useful comparison to be made when the questions were similar.

Visits to more than 50 hospitals in America and Britain had shewn the variation of design layout of hospital wards. Among those used in this study was an old style Nightingale ward - basically one very large room, the beds being arranged in parallel rows where every child could be observed from a central desk and a ward in a large modern hospital where children of school age could be found in 9 separate rooms with long distances between. The need of teachers would vary both with their own styles of teaching and the geography of the ward. This variation was borne in mind when questioning the teachers.

The Normal Role

The first questions were concerned with the normality of the role. The basics could not be taken for granted. Was the environment good or even adequate for the job? Did all the children attend school (or just some) and in what sense was the curriculum like that of a mainstream school? Environmental conditions were so variable that it seemed best to ask teachers to say how they viewed their venues and storage spaces rather than describe them. They could not ring a bell for start of school so when did teaching start? Was there school all day or just in the mornings? Was there a staffroom - this was defined as a room of their own where they could make a cup of coffee? Teaching aids might be scarce but did they have a universal aid - a television set?

Next, questions about the children. Were all children taught or were some like short-stay children excluded? Children who were medically too sick were exempted as were those with visitors; it might be said that 'medically too sick' was vague but experience indicated that there could be no definition as there were too many differences of opinion among medical staff even in one hospital. Did the teacher have sufficient

authority to act promptly and firmly to obtain medical help or have children removed from school, important considerations if the teaching venue was far from the nursing station? Were children taught in groups or only individually and how wide was the age range taught by one teacher?

Finally four questions on teaching methods. Did the teacher undertake projects and use assessment tests? Was she able to plan ahead? As an indication of range of teaching, did she include cookery, science* and drama - all of which should be appropriate subjects for hospital teaching. Summaries of the answers are to be found in tables 3:1, 3:2, 3:3.

Table 3:1 Employment and Previous Experience of Teachers Compared with Fassam

Summary of Responses	Fassam	P.W's Study
Type of Hospitals	All	General
Number of Teachers Interviewed	85	30
Number of Hospitals	28	20
Sex of Teachers - Women	98%	97%
Full Time	75%	50%
Previous Experience: Infant or Junior	46%*	73%
Previous Experience: Senior	30%*	33%
Employment in Hospital more than 10 years	17%	17%

* Approximate figures from Fassam account N=30

In table 3:1 two major differences should be noted. The larger number of part time teachers (50% P.W) and (25% Fassam) may be due to longer-stay hospitals included by Fassam having proper schools while

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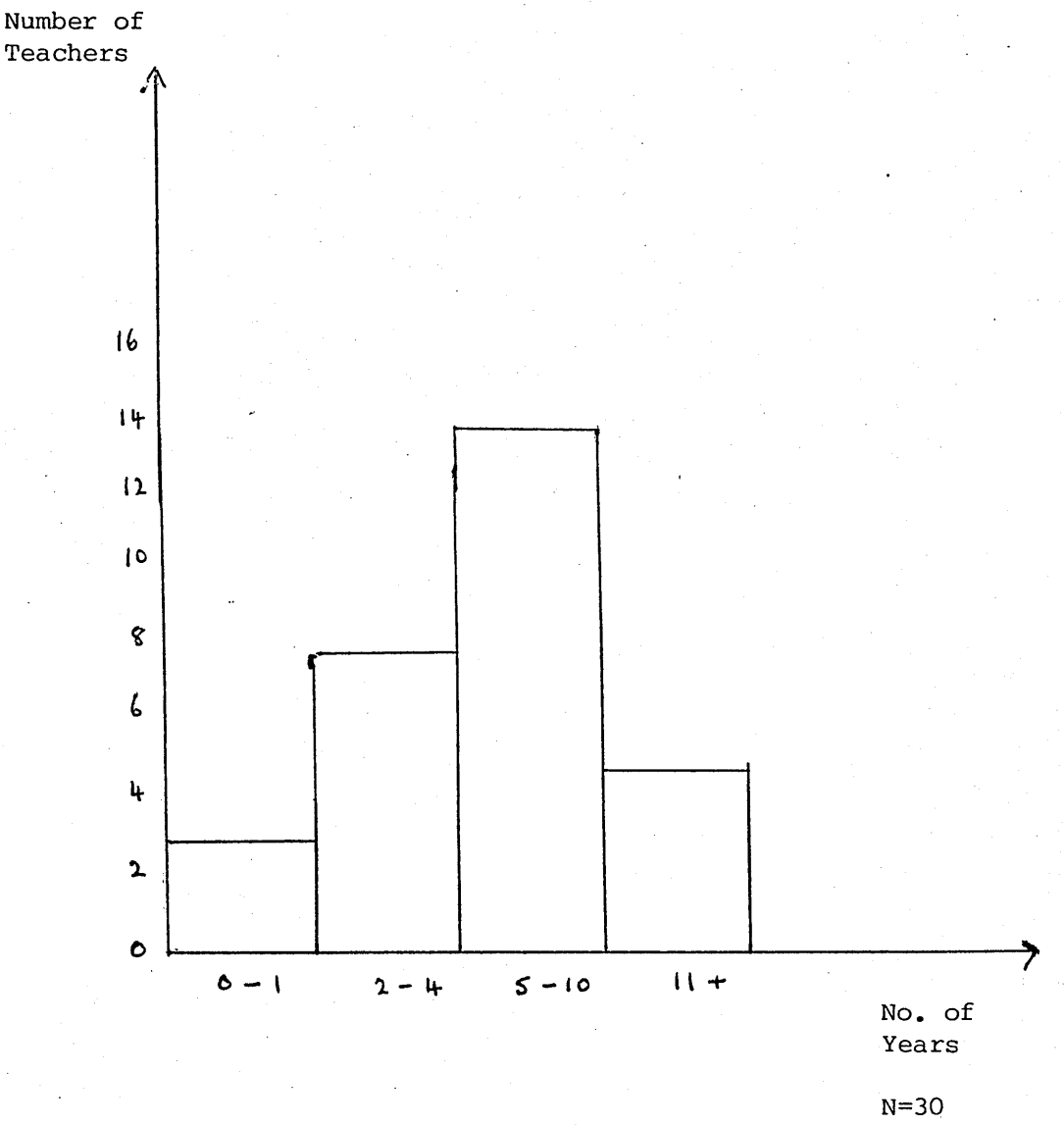
* Syringes, Thermometers, Pill Counters, Plastic or Paper Materials, Pulley's and much more equipment are available on every hospital ward and provide illustrations of topics generally studied in school.

general hospitals may employ lone teachers. The difference in previous experience would be explained by the same reason. Only large hospital schools can employ inexperienced or new teachers.

Table 3:2 Number of Teachers and Length of Stay in Same Hospital



A closer look will be taken at the answers in table 3:3. Most teachers, recognising the difficulties imposed by hospital design, were satisfied with the basic conditions. Almost all had access to television screens but in practice may not have made much use of them. For School to start at 9.30 am sounded late but in wards other than Nightingale the process of finding and bringing together children and equipment at a busy

Table 3:3 Do Teachers Undertake a Normal School Role?

Question	Answer		Summary%	
The Environment				
Use of T.V.	Yes	29	Yes	97%
	No	1		
Equipment and Storage	Very Gd	17	Good or Very Good	93%
	Good	11		
	Poor	2		
Teaching Venue	Very Gd.	15	Good or Very Good	87%
	Good	11		
	Poor	4		
School Start Time	9-9.15	10	By 9.30	83%
	9.30	15		
	9.45-10	5		
Availability of School	All day	18	All day	60%
	Mornings	11		
	3 mornings	1		
Staffroom	Yes	14	No	50%
	No	15		
	No Reply	1		
The Children				
Children not taught	Short Stay	2	None	90%
	None*	27		
	Not Clear	1		
Group Teaching Undertaken	Yes	27	Yes	90%
	No	3		
Adequate Authority	Yes	16	Yes, Usually	83%
	Usually	9		
	No	4		
	No reply	1		
Age Range Taught	4/5-13/14	5	At least 5-16	80%
	4/5-16	18		
	4/5-17+	6		
	Under 4	7		
The Teaching Policy				
Forward Planning Undertaken	Yes	13	Some Planning	80%
	Limited	11		
	No	6		
Projects Undertaken	Often	11	Some - Often	67%
	Sometimes	9		
	Occasional	9		
	Not Relevant	1		
Use of Assessment Tests	Some	3	Definitely No	60%
	None	18		
	Unclear	9		
Teach Cookery, Science, Drama	Cookery	20	At least two	50%
	Science	17		
	Drama	13		

* Children too sick or with visitors excepted N=30

period of the day could take a long time. Only 50% of teachers had a staffroom which could imply a lack of status but, in conditions where even Nursing Officers shared rooms it was hardly surprising.

What about the children? A school assumes that all children will be taught. Education Authorities may recognise only the teaching of long-stay children where long-stay could be defined as 1 week or 1 month or any other period. In practice what did these teachers do? 90% said they taught all children and 90% taught them in groups as well as individually. Since 'school' for children implies a number of children it would be more normal if group teaching were undertaken. The answers to the 'Authority' question shewed a not altogether satisfactory state of affairs. In the management of sick children all teachers should have adequate authority and 'usually' is not good enough. The most general age range taught by these teachers was 4/5 - 16 which was a wide spread when compared with teachers in mainstream schools. 47% of teachers with no previous secondary experience were teaching children up to the age of 16 but more than half of these were graduates so that at the most 20% may have been insufficiently qualified.

Teaching policy varied. The adaptability needed by a teacher whose pupils were constantly changing might lead to a feeling that it was useless to plan ahead but 80% said they did some planning. This would be essential if projects were undertaken as they were by 67%. Projects were more likely to be undertaken as the need arose than according to any set policy. Assessment tests were very unpopular as they were thought too threatening for use with sick children; so how did teachers set about teaching subjects like mathematics?

Certain subjects like Mathematics and French are conceptual subjects. Each piece of learning is apt to depend on the understanding of a previous process. A child absent from his own school may become very

confused. Experience of teaching adults Mathematics has shown the importance of continuity in the progression of learning. All teachers had said that they regarded Remedial Teaching and Mathematics Teaching as very important. Many said that they would talk to a child about his work and interests and would then either offer him work below his supposed standard or give him a suitable game. They would then observe how he progressed. From a successful start it was possible to build upwards and find and plug the gaps of which there were usually a good number. Two comments were of interest. One teacher expressed relief that there were no mathematics teachers in her hospital as she would feel threatened if there were! Another said that the school secretary was the adviser as she was the only one to be qualified mathematically! The Cockcroft Report highlighted the failures in Mathematics teaching in normal schools and the standards must be seen as universally in need of improvement. It was in general only possible to say that, while the ward situation was abnormal, the task undertaken by the teachers seemed in practice to be similar to that being undertaken in Primary and Middle schools.

In the practice of teaching it seemed possible that some might restrict teaching as did many American teachers to keeping children up with the three R's or examination subjects. The amount of Art on the walls of British Hospitals made it seem likely that this was also a basic subject, but would these teachers also try cookery, science and drama? Cookery was chosen because food is a very important topic to a hospitalised child; Science because the hospital provides an enormously rich scientific environment and Drama because of its universal appeal even to the bedridden. 87% of the teachers undertook one of the three subjects. 50% undertook two. It could be that in this area there is room for expansion but it is also possible that only those teachers who had assistance could undertake such teaching.

The teachers in this survey did perceive a normal school role. The age range taught might be unusual and lack of testing a challenge but they were intent on teaching all children and were not operating an individual tutorial session such as that often envisaged by those who had little experience of hospital wards, whether education authorities or not.

The Situational Role

The second role to be considered was the situational role. Did the teachers feel they had a special role due to the illness of their pupils? There was no special training for a hospital teacher and only 17% had a qualification in Special Education, all of whom where older teachers. How did the teacher find out about the child's medical condition? Did the ward staff tell her or did she look in the Cardex (daily ward notebook)? Did she allow some play in school? Did she encourage medical play such as with a toy hospital or an injection syringe which would involve discussion about the hospital experience? Did older children write about their experiences or use hospital related workcards? Did she try to alleviate the frustrations of the child who was enclosed on a hospital ward by moving beds or pushing children out in wheelchairs? Teachers were invited to comment on these questions and the answers are summarised in table 3:4.

The replies to this section were of interest. An increased counselling role was undertaken by 83% of the teachers and in discussion a number said that the opportunity to meet and talk with families as well as children was most valuable. If the child was short-stay in the hospital, the teacher might make suggestions of further work at home; if the child was long-stay she could act as a go-between with the child's own teacher. It is not always so easy in the case of mainstream school-teaching to understand the nature of the difficulties occurring for the

Table 3:4 Do Teachers Undertake a Situational Role?

Question	Answer		Summary	
Increased Counselling Role	Yes	25	Yes	83%
	No	5		
Information on Child	Via Staff	6	Staff or Cardex	70%
	Via Cardex	7		
	Via Both	8		
	Variable	5		
	None	4		
Play & Hospital play	Play	8	Play	67%
	Both	12	Both	40%
	None	9		
	No Response	1		
Move beds	Yes	18	Move beds	60%
	No	11		
	No Response	1		
Hospital related work	Yes	11	Yes or Some	57%
	Sometimes	6		
	None	11		
	No Response	2		
Take children out	Yes	14	No	53%
	No	16		

N=30

child and, for example, sometimes the suggestion of simple games at home to help with number work could ease a learning difficulty.

Information about children was adequate if it came from staff or cardex (70%) (Fassam found 90% of teachers based in a hospital school had access to the ward notes while only 40% of lone teachers did so).[10] In this sample 50% had access to cardex. Nursing Reports are oral and for speed of up to date information this may be quite adequate for the teachers in most cases. However prevention from access to the cardex is another matter and would seem to indicate a lack of cooperation. Those who were dissatisfied made the following comments:

- Sister gives inadequate information
- I am forbidden to read the notes
- I did not know there was a ward book
- I find out by chance
- I ask the child (Another teacher warned of the

dangers of this procedure)
- I avoid knowing too many details as I find it too upsetting

67% allowed play in school and this might seem surprising. Indeed one teacher said "Play, No! We do what is our job." Fewer teachers related the play specifically to the hospital i.e. by using a toy hospital, imitation medical equipment, hospital play people etc. While hospital play might relate more to younger children it should be remembered that 80% of these teachers said they taught the age range 5 - 16 and so must consider the needs of quite young children. 57% sometimes gave hospital related work - this was not a large number considering the opportunity available to make use of this new environment. 60% moved beds which enlarged the scope for the bedfast but less than half ever took children out.

Most teachers did recognise a special role due to the situation of the pupil as a patient and most but not all were satisfied with the system of communication with the medical staff. They were divided in their use of hospital related play and work and for some it may never have been a consideration.

The Social Role

The next questions were concerned with the Social role of the teacher. The hospital was medical territory with the teacher working on one or more of the wards. The Sister was head of the ward and there would be others to whom it was essential to relate. Fassam commented:"In view of the central role of the ward sister for teachers, parents and children, it is striking that both teachers and hospital administrators reported that in only about 3% of hospitals was the ward sister involved at the time of the teacher's appointment."[11] Fassam's comment did not surprise the teachers many of whom may have started work with few instructions and fewer introductions. Was the teacher introduced to the ward sister when

she started work, and even if the start was unpropitious how did the relationship appear now? Then there were the doctors who might appear infrequently but perhaps they needed an assessment while the child was in the hospital. Sometimes a teacher might notice abnormal learning or behaviour problems while the child was in school or hospital. These could relate to the accident or illness and might be indicative of a possible need for psychiatric help. It might be a rare occurrence but had the teacher requested such help for a child in the past 5 years?

Cooperation between staff in hospital has been shown to be important to achieve any kind of efficiency. A number of children who enter hospital would need the care of a medical social worker and it would be helpful for the child's progress if understanding links were made with her and the parents. In cases of extreme social need the hospital school could sometimes offer considerable remedial and restorative education but only if the teacher had some awareness of what was happening outside the hospital. Relations with the Playleader were of prime importance: both were on the ward so what did the playleader do? Did she help the teacher or did she look after the needs of the under 5's? Hospitals have of recent years become much more open to parents, so how did the teacher cope with the parent/child situation? A teacher would never in normal school expect to teach mathematics to a 12 yr old boy whose mother was with him' Volunteers may not be abundant but there were some and they could take on the temporary role of a granny thus freeing the teacher for others. How many teachers made use of this help in practice? It has been shown that there were a number of staff with whom the teacher would interact: the physiotherapist, the ward clerk, the cleaners and the occupational therapists - to name but a few. However the medical social worker, the playleader, the parents and vounteers would have especially close links with the teacher.

The last questions tried to probe how the teacher felt about her wards. She might have no other teacher colleagues and be reliant for social mixing on her colleagues in the hospital. She was an outsider, but there were many others also who were not nurses or medical staff. How close did she feel to the staff? Party invitations are usually spread wide and she might well be included; but would she like to see closer links? The responses are summarised in table 3:5.

The failure to introduce teachers properly on the wards (73%) led to difficulties for the teachers. The lack of this introduction meant that the teacher must steer her own way in meeting every single member of staff, and it was remarkable and a tribute to the teachers that 70% should say that relations with the ward sister were now Good or Very Good. More than might have been expected (67%) had written a report for a doctor and surprisingly 57% had suggested the need for a psychiatrist. Teachers are used to dealing with normal school age children and would be in a strong position to be aware of difficulties when this age group were in hospital. This is an area where communication among ward staff might be of the greatest help.

A large number of teachers interacted with social workers which was encouraging. Parents however were not always welcomed. This was short-sighted because others found that if parents were made welcome and saw their child happy, they were grateful to be free to leave. Perhaps some teachers have not seen the possibility of using volunteers. Not all volunteers are an asset but a working relationship with the Voluntary Services Organiser does lead to an invaluable aid to the teacher who is so often faced with children in need of so much individual attention. The lack of breadth of the curriculum has been the subject of comment and it is interesting to note that of the 50% of teachers who undertook the teaching of two out of Cookery, Science and Drama, 73% had some

Table 3:5 Do Teachers Perceive a Social Role?

Question	Answer		Summary	
1. Ward Sister Relations				
Ward Sister Relations	Very Good	9	Good or	
	Good	12	Very Good	70%
	Fair	9		
Introduced to Sister	Yes	8	Yes	27%
	No	13		
	Incidentally	9		
2. Doctor Relations				
Write reports	Yes	20	Yes	67%
	No	10		
Psychiatrist suggested	Yes	17	Yes	57%
	No	13		
3. Ward Relations				
Social Worker links	Yes	23	Yes	77%
	No	7		
Playleader role	Interacts	6	Under 5's	60%
	Solely under 5's	18		
	None	6		
Attitude to Parents	Welcome	18	Welcome	60%
	Exclude	12		
Use Volunteers	Yes	18	Yes	60%
	No	12		
4. Personal Feelings				
Feel staff member	Yes	24	Yes	80%
	Sometimes	2		
	No	4		
Party Invitations	Yes	24	Yes	80%
	No	5		
	Seldom	1		
Want closer links	Yes	18	Yes	60%
	No, Satisfied	12		

N=30

volunteer help while 27% had none. Relationships with playleaders could be difficult because often they, like the teachers, do not have a clearly defined role. The teachers were asked to say what happened in practice during school hours. The majority of playleaders (60%) took on the

under 5's but 20% interacted with the teachers. There is a real problem for the playleaders here; they are trained for the youngest age group but appointed to all. If the teacher took over the older children during school hours, could the playleader relate to them in the time left?

The great majority of teachers (80%) did receive party invitations and felt like staff members which was encouraging. However they would have liked closer links, but the nature of these was not specified. The teachers did not appear to be able to make all the links professionally desirable in the situation through no fault of their own. Perhaps counselling or social skills should appear high on the list of requirements in training.

The Outspan Role

Lastly an investigation was made of 'the outspan role' of the teacher. How extensive was this? An outspan role is seen as concerned with contacts with the child's own school, arranging home tuition when permitted by the authority (as Fassam found, very variable), visiting mainstream schools for oneself and meeting other hospital teachers. This included having local schools visit, arranging tuition for children on adult wards and invigilating examinations in this role. The answers follow in table 3:6.

In this study the teachers, 90% (or more), saw that as part of their role they would sometimes need to contact a child's school, arrange home tuition or teach a child on an adult ward. This would be undertaken by themselves or a colleague. 25% of Fassam's teachers never contacted a child's school, but perhaps that only meant that the head of the hospital school saw this as his task. It is not clear. Most individual teachers in the Fassam study never made arrangements for home tuition. The difficulty is that the process of organisation is slow anyway and Fassam said "Among the families interviewed who had a need for this service, it had proved

Table 3:6 Do Teachers Perceive an Outspan Role?

Question	Answers		Summary	
1. Comparison with Fassam				
Contact child's school	Sometimes	30	Sometimes	100%
			(Sometimes	70%)
Arrange home teaching self or colleague	Yes	28	Yes	93%
	No	2		
(Hospital School Teachers			Yes	90%)
(Individual Teachers			Yes	35%)
Visit mainstream school	Yes	24	Yes	80%
	No	6	(Unusual)	
Meet colleagues	Often	9	Termly	57%
	Once/term	8	or more	
	Sometimes	13		
	(More than once a year			25%)
2. Two Additional Questions				
Invigilate exams (or a colleague)	Yes	22	Yes	73%
	No	8		
Local schools visit	Yes	10	No	67%
	No	20		

( ) indicates Fassam response N=30

impossible to arrange in almost all cases."[12] The carrying out of the arrangements was of course outside the province of the hospital teacher but the failure of a request by a teacher would not aid the families. Fassam reported on the difficulty teachers have in finding children when they are on adult wards. Computerisation could make the task easy, but up till now it has seldom been used and might not be possible in smaller hospitals. It is possible for a child to be on an adult ward for many weeks before a teacher is requested and then only because a ward clerk has remembered a previous teacher who has visited. It is difficult to allow a budget for this sort of irregular teaching.

80% of teachers had visited a mainstream school in the past two years. The expansion in teaching methods with the general opportunities to use microcomputers in the junior schools make the visits important

inservice training for hospital teachers who are dealing with the normal school population. It was unusual for the Fassam teachers to have visited a mainstream school.[13] These teachers met colleagues quite often (57% as often as termly) while only 25% of Fassam teachers met more than once a year.[14]

Answers to the two additional questions revealed that 73% had known of examinations invigilated by a teacher, often a last minute arrangement because of unexpected hospitalisation. Visits by local schools appeared a good idea but the child patient might find them obtrusive or a non-event. It is for many reasons difficult to commit staff to looking after visitors and it was interesting to know if such visits (other than carol singing) took place. In most hospitals they were not encouraged.

Most teachers in this study did then perceive an outspan role relating to a child's home and his own school. Also most were aware of a need to provide teaching on adult wards. However links with local schools were few.

From the results so far, it can be seen that teachers in hospital are taking on some unfamiliar roles. 83% had reported an increased counselling role (table 3:4) and 80% had found an identity as a member of the ward staff (table 3:5). Had they obtained help from any sources to undertake these roles; would they like help? Were the rewards they experienced in teaching in a hospital different and related to the new roles or were they the same as in ordinary teaching? A summary of the answers to the following two questions is to be found in table 3:7.

-q1: Detail any courses which have helped you since you became a hospital teacher
-q2: State any courses which might help you.

Table 3:7 Helpful Courses

Question	Helpful Past Course	Helpful Future Course
Normal Curriculum Courses		
Mainstream Courses	6	5
Remedial Maths/Reading	4	3
Art/Craft/Music/Photography	6	4
Special Courses		
Multicultural needs	1	0
Special Ed. or Handicapped	2	1
Hospital Related Courses		
Child Psychology/Illness	3	6
Hospital/Home Teacher meetings or courses	7	1
Social Skills/Counselling	0	4
No Courses		
None	6	8

N=30

The maximum possible number of responses was 30 so that it can be seen that there was no overwhelming demand for any particular course although the single most popular had been hospital teacher meetings. Interestingly of the 6 who had previously never attended any course 3 would like counselling and/or child psychology. Possibly those teachers felt they had already learnt what they need by experience on the wards so that it might be more indicative to see what courses they would recommend for a teacher new to hospital teaching. The next question asked teachers to number 9 possible courses in order of importance. Electronics was added to the previous list because of the plethora of electronic teaching aids available and the arrival of computers in the schools. It could be an exciting new field for teachers. Since the questionnaire was being filled in quite fast without any lengthy consideration, the position of a choice in the first three or in the last three might be the best indica-

tor of status. The number of first and last choices could also be indicative of feeling. The results are in table 3:8.

Table 3:8 Courses For New Teachers

Subject Choices	First	Last	First 3	Last 3
Normal Curriculum Courses				
Curriculum	0	5	2	15
Remedial Teaching	0	0	9	3
Art/Craft	1	3	5	13
Hospital Related Courses				
Hospital Visits	15	1	20	4
Childrens Diseases	1	2	5	12
Child Psychology/ Illness	10	0	22	2
Social Skills	2	0	15	9
Counselling Children	0	1	7	6
Special Courses				
Electronics	0	16	0	24

N=30

Several teachers said that in answering this question they would assume the entrant already possessed sufficient skills in both general and remedial teaching when she applied. The two majority first choices were visits to other hospitals and Child Psychology as it relates to illness. As the largest number of positive responses to most helpful past courses had been concerned with hospital teacher meetings this was not surprising. The second subject of importance, Child Psychology, was that about which the largest number of existing teachers would like to learn. Amongst the first three this subject was thought of importance by 73%. 50% thought social skills important but the question may not have been clear as several teachers asked what was meant. It is not surprising that the hospital related courses were thought most suitable for teachers entering a new field, but what was surprising was the position of children's diseases in the last three choices. A knowledge of how a child may

be feeling and thus his response to teaching does in many cases relate to the progress of his disease or postoperative condition. Perhaps the knowledge was thought to be acquirable by experience. 67% of teachers placed electronics in the last three - it aroused little interest at that time but such has been the speed of development of computers that attitudes may well have changed.

Finally it seemed important to try to understand why teachers enjoyed hospital teaching. They remained in hospitals for a long time. Was it because it was an easy job or did it relate to the additional roles which have been perceived for a hospital teacher? The question asked was "What rewards do you find in this type of teaching?". The answers have been categorised in table 3:9 and some teachers gave more than one response.

Table 3:9 Reasons for Teaching Children in Hospital

Normalcy of teacher's presence increases happiness of children	53%
Close relationships with families	30%
Enjoy helping sick children	20%
Enjoy working in hospital environment	7%
Not rewarding	3%

N=30

The following were among the reasons given:

- I see sick children come to life
- I get children involved and happy
- The reward is in knowing that you have helped a child to cope and grow through the experience
- In seeing therapy work on children
- In making close personal relationships

Why had one teacher found it so frustrating that she intended to leave? Certainly not because she did not perceive the therapeutic possibilities, but rather because she was among those who were not accepted as ward staff, who had no access to information about the children and who were for the most part denied a social role in the hospital.

In this study career prospects and salaries were not mentioned when rewards were considered. Conditions of employment are variable and promotion is unlikely but on the other hand there are seldom examination pressures and few disciplinary problems are to be found. Teachers who expressed their reasons for finding the task rewarding saw themselves contributing to the welfare and happiness of the children in enacting the normal school role to which they were accustomed, and in the course of it providing a therapeutic service. About half went further and provided play or hospital activity in a more deliberate manner. In order to carry out these tasks they recognised a need for adequate social relations on the wards with other members of staff and 60% requested closer links. Visits to other hospitals, instruction in child psychology specific to illness and training in social skills were thought by many to represent the most helpful provisions their superiors could provide.

Fassam concluded that "the functions of education in hospital may be thought to be similar to those in ordinary schools, although the population of children in hospital has distinct needs and problems."[15] She went on to say that some teachers adopted a dual approach, using the hospital itself as a basis for the short-stay pupils while the longer stay pupils followed their own curriculum. She noted however that not all teachers would agree with this or feel equipped to carry it out. She also talked of the isolation both personal and professional of the lone teacher and went on to say:

> Until there has been a full discussion within and outside the profession of the role and purpose of the hospital teacher in the face of children of a diversity of ages, abilities and needs, it is likely that some teachers will continue to feel that they have been set an impossible task and that all they can do is to 'occupy' the children in their charge.[16]

Yet in her concluding paragraph she evaluated the teacher's role in these terms:

> Their contribution to the inter-professional team caring for children in hospital is potentially considerable, especially for the longer stay child and those who need to come back to hospital regularly.[17]

Like the teachers in Fassam's study those involved in this study taught a very wide age range of pupils, but, unlike some of Fassam's teachers, they did not appear to think they had been set an impossible task. They expressed no concern as to what they should teach. They had rejected assessment as a way to discovering what was appropriate for the children who came to them and had devised a variety of strategies for determining how and what to teach. Overall their view of the curriculum did appear rather narrow, though if a volunteer could be found to help the range of possibilities might be expanded. But in view of the Oracle study it is impossible to say whether their attitude to projects was more or less positive than that of teachers in mainstream schools. Fassam's teachers were divided in their opinions as to the use of hospital based studies. The same division was evident among these teachers who were equally divided between the two approaches. Fassam said that some teachers felt ill equipped for such environment teaching, and some of those interviewed in this study may never have considered it as a possibility. Because of their special situation in a hospital, they were sometimes involved with the families of the children. This aspect of their role, which would seem to be encouraged by the Oxford advisers, was clearly felt to be most important and valuable by the teachers themselves.

There are many children in hospital who, despite their illness can manage to concentrate on schoolwork for reasonable periods of time provided these are interspersed with play. Either the teacher can equip them with play materials and return to school work at appropriate intervals or she can leave the child to his own devices. Some teachers feel that it is not their role to meet these needs of children which are not specifically educational. However the view of the majority (67%) was that play should sometimes be allowed and should be seen as falling within their scope as teachers.

Fassam had been concerned with the isolation of the teacher and certainly this study pointed to how it originated on the wards. The social role of the teacher is important for the child. No professional person should go to work in an institution without benefit of support and it is greatly to the credit of those who took part in this study that most had survived the isolation. More interprofessional meetings are needed. If these lead to better and faster communication it will be very worthwhile.

Fassam asked parents about the arrangements for home teaching if the child had to stay at home for a period following hospitalisation. Their replies were universally negative, they had achieved nothing. Fassam found a contradiction here, for, on asking hospital teachers whether or not they had contacted the home teaching service, 90% of hospital school teachers and 35% of individual teachers had done so. Most teachers in this study had also made the contacts.

An attempt has been made to find out how 30 teachers from 20 general hospitals in different parts of Britain viewed their role. The great majority said that they taught all the children, providing a limited curriculum with plenty of remedial studies. The employment of volunteer assistants often appeared to coincide with a rather broader syllabus.

Most felt themselves to belong to the hospital staff as well as the education department and so have a social role in the hospital. 80% of teachers said they had an increased counselling role due to teaching in a hospital rather than a school and all said they made contacts outside the hospital with the child's school when necessary. Many teachers, when asked what rewards they found, said their reward lay in perceiving the happiness of children who could take part in near normal school tasks although they were living in a hospital.

Twenty one out of the thirty teachers had children of their own. Their belief in the therapeutic nature of the role was an echo of the beliefs expressed in the Kingston papers.[18] They viewed the children both as parents and teachers. However in a time of financial stringency the question of how teachers spend their time has become important. When education committees meet there are those who declare that teachers should teach and playleaders and others should undertake therapy.[19] Hospital teachers are a very small specialised group and although they may be supported by consultants, nurses and other hospital staff, it is necessary for them to show that their role is indeed educational.[20] The next task must be to look at what is happening on hospital wards and to try to see what children are doing during school hours when there is a teacher compared with when there is a tutor for an individual child or sometimes no teacher at all.

Four wards were chosen for the British study. Three were chosen because of their easy access for the Observers and the fourth because it was a ward without a teacher. There was no commitment to any particular style of teaching and it was entirely in the hands of the individual teachers as to how they proceded during the study.

Summary

Four roles are proposed for the teacher: the normal school role, the situational role, the social role and 'the outspan role.' Recent research, the Oracle study, gave a basis for what might be considered mormal in educational practice. Almost all the teachers said that they taught all children but they taught an unusually wide age range and a limited curriculum. The situational role or the special role due to teaching in a hospital was not undertaken by all teachers. Most did increased counselling and allowed play in school but only just over half encouraged hospital-related work. In considering the social role, 80% of the teachers said they did feel themselves to be staff members, but as only 27% were introduced to the ward sister on appointment and most wanted closer links with the ward more thought needs to be given to the interdisciplinary aspect of the role. In addition attitudes to parents and volunteers and interaction with playleaders appeared to need a careful review. When teachers were asked why they found the work rewarding, the most common reason they gave was that they believed that the normality they provided led to increased happiness for the children. The teachers perceived a therapeutic role but it is possible that while the ideal provision is for all children in practice it would not be possible for a teacher to carry out such a task.

References

1. Galton, M., Simon, B., and Croll, P., "Inside the Primary Classroom", Routledge & Kegan Paul (1980) p.48 (Plowden par 505).

2. Op.cit.(1), p.57.

3. Op.cit.(1), p.155-161.

4. Op.cit.(1), p.70.

5. Fassam, M., "Education for Children in Hospital." N.A.W.C.H. (1982).

6. Ibid. 5.

7. Op.cit.(1).

8. Pope, M., "Monitoring and Reflecting in Teacher Training" in Fay, F.(ed.), "Personal Construct Psychology", Academic Press (1978) p.75-86.

9. Op.cit.(8), p.76.

9a. The importance of discrepancy of perceptions is discussed by F. Clough in 'The Validation of Meaning in Illness-Treatment' in Hall, D. and Stacey, M. (eds.) 'Beyond Separation', Routledge and Kegan Paul (1979).

10. Op.cit.(5), p.10.

11. Op.cit.(5), p.14.

12. Op.cit.(5), p.26.

13. Op.cit.(5), p.10.

14. Op.cit.(5), p.10.

15. Op.cit.(5), p.27.

16. Op.cit.(5), p.27.

17. Op.cit.(5), p.28.

18. See above ch. 1, p.14.

19. Oxfordshire County Council Education sub-committee, May 26th, 1983.

20. See above ch. 1, p.15.

Chapter 4

What Difference Does a Teacher Make? Ward Studies in Britain

From the study of how teachers view their role certain expectations of what is likely to happen in practice may be derived. All children of all ages will be taught and the curriculum will be similar to that found in main-stream education. Increased remedial teaching may be expected and there may be some study of the hospital environment. Some indication of an increased counselling role may be anticipated but it is not possible to guess in advance what form this will take.

A study was made of four children's wards in four different hospitals, one of which had no permanent teacher, two of which had a teacher in the mornings and one of which had a teacher all day. It was hypothesised that the presence of a teacher would make a difference to the child as N.A.W.C.H. had suggested in its policy statement. Teachers would offer stimulation and a link with normality and some would enhance and explain the hospital event. Their presence would help reduce the stress for the child. It was judged that the detection of that quality of 'aliveness' which was the opposite of 'deadness' or 'boredom' in institutions would be an important aspect of the study. The ward without a teacher will be presented first so that there may be some appreciation of the difference made by the presence of a permanent teacher.

The activity of child observation on hospital wards has numerous pitfalls. It requires, quite rightly, the consent of Administrators, Senior Nursing Personnel and Consultants. That is the official side and but a beginning. In addition it needs the active support of the Ward Sister and all who work with her, together with the consent of the therapists and others involved from time to time with children. Then it needs the active support of the teachers and the permission of the

parents. In addition, it was decided that an explanation should be given to the older children. The researcher was herself a non-participant observer, having worked part time as a hospital teacher for 14 years. She recruited 4 volunteers to help her. Two volunteers had previously assisted the teacher in school; the third, who was herself a teacher, had to abandon the study because of illness and the fourth was the parent of a child who had been hospitalised for a long period. All were married women with much experience of children. Each of the wards was observed by both the researcher and a volunteer.

The studies were planned to take place on 6 wards - five days being spent at weekly or longer intervals on each. However one ward had to be abandoned because the Observer's husband fell ill and another abandoned because the presence of an Observer was thought to be too intrusive. Thus four wards remained in the study. Two were of the Nightingale type, most of the children being in one very large room with tables in the middle. It was not easy to be unobtrusive but, as far as the children were concerned, the presence of yet one more middleaged lady probably made little difference because there were already so many strangers who were relatives or friends of other children.

The Observers were supplied with code cards and code sheets (see Appendix 3). A code card was developed which was designed to enable them to categorise the activities of every school age child on the ward at ten minute intervals. On the largest ward this activity took three minutes out of each ten. The other 7 minutes were spent in making a fuller written description of the events. The observations took place during school hours with a break for lunch and the children's rest time. Observers were trained by working alongside the researcher until she was satisfied that their coding agreed. At first observations were tried every 20 minutes but the rapidity with which children changed their

occupations caused the interval to be halved. As well as coding the activities of the children, symbols were used to codify the director of the activities if this was not the child himself.

Playleaders directed activities but it should be remembered that the playleaders, when they were present had responsibilities to children who were under 5 years and their few appearances in these studies in no way reflects the full range of their activities.

Each Observer accompanied the researcher to her ward on a prior visit to meet the staff and study the geography. It was not an easy task to install oneself on a strange hospital ward and it was undertaken in some trepidation. However all recorded the welcome they received from the teachers in particular and from almost all the ward staff in general. Those parents who expressed an opinion were very much in favour of research which might in any way encourage the provision of teachers in hospitals. Those nurses who already had teachers present in their hospitals said how important they were and a consultant said that he thought school was more important for his patients than hospitalisation. However, the recording of staff opinions was not part of the research.

The Observers were instructed not to speak to children and if children spoke to them to answer in a manner which implied they did not wish to continue the conversation. For two Observers this prohibition on communication was quite difficult. However, the employment as Observers of people who could understand and relate to children very easily was thought to be beneficial to understanding the activities which would be pursued by the children. Before describing each of the wards in turn it is necessary to make a comparison of the children on all four wards to see whether they suffered from the same illnesses, were equally mobile, covered the same age range and had spent the same amount of time in hospital. Three of the four wards were combined medical/surgical and ward

D was entirely surgical. The answers are summarised in tables 4:1 - 4:4.

Table 4:1 Reason for Hospitalisation

Diagnosis	Ward A	Ward B	Ward C	Ward D
Orthopaedic	4	0	0	15
(Fractured Femur)	(4)	0	0	(4)
Ear/Nose/Throat	10	1	0	0
(Tonsillectomy)	(9)	0	0	0
Gastrointestinal	8	11	5	13
(Appendicectomy)	(2)	(5)	(1)	(3)
Renal/Urinary	0	4	1	0
Investigations	1	0	3	0
Neuro-muscular	4	0	3	1
Metabolic/Endocrine	4	6	3	1
Respiratory	2	7	7	0
(Asthma)	(1)	(6)	(7)	0
Cardiac	0	3	0	0
Miscellaneous	10	3	7	2
Total	43	35	29	32

It can be seen that A had 9 tonsillectomy cases and this was on a ward where there were few single rooms and Observers were not permitted on post-operating days. Ward B had 5 children with appendicectomies, and both B and C had a number of children with asthma who would be accustomed to making regular visits to the hospital. D was an accident ward and the fractured femurs were but a few of the immobile children. Orthopaedic cases were not sent to wards B and C and tonsillectomies or medical cases would not be found on D. However a wide variety of illnesses were to be found on all four wards. Children who made recurrent visits would need the normality of education and children who had been in accidents would

need the security which school gave with its connections in the real world.

The total number of different children who appeared on each ward during the course of the study has been given in table 4:1. In the following tables the same child may appear more than once because each day's visit was treated as unique in compiling the tables. The purpose was to compare the groups of children which confronted the ward personnel on each occasion. In most cases there would be no way of telling how long a child might remain in hospital. Parents are apt to think that the hospital staff are unnecessarily vague but frequently sick children unexpectedly make good progress and then are rapidly discharged home. This is difficult for the teacher who, while she may know that a child with a fractured femur usually stays several weeks and a tonsillectomy 2-3 days, may have no idea of the length of stay of a child admitted for investigations. The figures given in table 4:2 are for the time already spent by each child in the study and give no indication of how much longer the child would have to stay.

Table 4:2 Number of Consecutive Days already spent in Hospital

Ward	1-3	4-6	7-10	11-20	21-365	Total for more than 1 week
A	21	14	5	2	1	8
B	18	11	3	1	1	5
C	17	7	4	1	6	11
D	18	10	5	3	8	16
Totals	74	42	17	7	16	40

The smallest number of children to have stayed in the hospital for more than one week were to be found on ward B with an average of 1 per

visit and the largest number was to be found on ward D with an average of three per visit. The mobility of the children affected both what the children might learn and in some cases whether they might be able to join the other children for classes. If the children were immobile everything would have to be brought to them and this could take a good deal of the teacher's time. Table 4:3 summarises the position.

Table 4:3 Mobility of Children

Ward	Mobile	Immobile	Total
A	35	8	43
B	27	7	34
C	27	8	35
D	12	32	44
Totals	101	55	156

It can be seen that D differed from the other 3 wards in having a high proportion (73%) of the children immobile. Almost all children who entered hospital are initially upset and need reassurance and a conflict of demands may arise for the teacher who must provide for all the needs of a number of immobile children at the same time as providing for the acute needs of even one unhappy child.

The immobility of the children causes some problems for the teacher but these are made easier if the children are homogeneous in age. The next table 4:4 summarises the ages of the children to be found on the wards during the course of the study.

Wards A and B had a large number of young children and C and D very few. Ward A had no teenagers, C and D could be expected to orientate to

Table 4:4 Age Range of Children

Ward	4-7	8-12	13-16
A	23	20	0
B	19	7	8
C	2	22	11
D	4	31	9
Totals	48	80	28

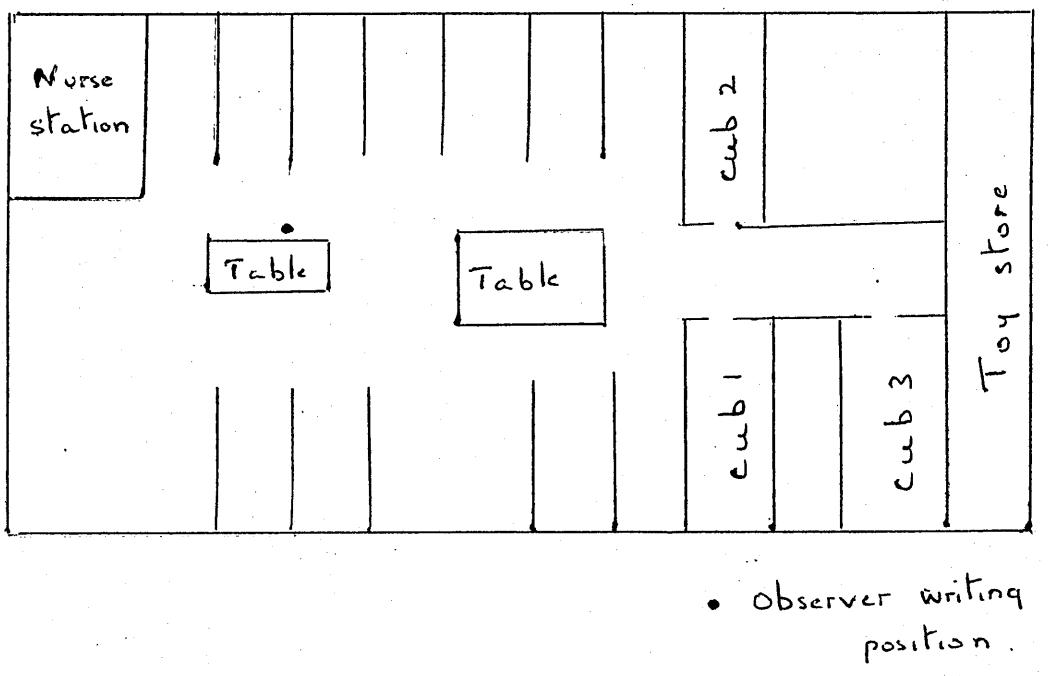
the middle school age range and D in particular had 3 times as many children in this age group as in the teenage group. A problem arose as to the inclusion or otherwise of 4 yr. olds. Since children of this age are sometimes admitted to school, a decision was made to include them in the study. The number of 4 yr. olds present each day is however noted in the tables.

From these tables it is clear that differences of disease, length of stay, mobility and age range existed and would affect the occupations of the children. These occupations will now be studied and each of the ward settings will be described in turn. Children will be depicted who appeared on these wards over the 5 days. Tables will show how the children were occupied during morning and afternoon sessions and the apparent anomalies will be analysed.

Ward A

In the first ward most of the children were in one large room which had several tables and one or two small armchairs in the centre. Parents were present and conditions by modern standards were fairly crowded. As has been stated Observers were not always permitted, but when they were present the atmosphere was most often very friendly and considerate.

Ward A



Staff

No permanent teacher
No playleader

Children

14 beds

Visiting

10 am - 7 pm

Age Range Observed

4 - 12 years

This emanated from the ward sister and reached to the ward cleaners. It would be as important to the children and parents entering the ward as it was to the Observers. There was neither teacher nor playleader but a social worker could be asked to obtain a tutor for long-stay children and during this study two tutors visited individual children. In the study (t) will refer to teacher for an individual child, (T) a teacher for a group of children and (p) a playleader. The Observer sat at one of the central tables partly hidden by a goldfish tank or large toy and managed to remain unobtrusive. Altogether 43 children were observed

between the ages of 4 and 12, but those incapable of activity, i.e. immediately postoperative or unable to be present for at least 4 x 10 mins sessions, were unrecorded. When it was observed that children's activity categorised as 'G' referred to some children who were undertaking one game continuously and to others who changed their occupation very frequently, a decision was made to categorise separately as continuous games all those undistracted game periods which lasted longer than one observation. In the tables the total games periods are noted and the continuous games periods are categorised separately. The percentage of time spent in work type activities or continuous games is given. The results for the morning sessions are shewn in Table 4.5 and afternoon sessions in Table 4:6.

When the observer started work on the first morning, there were ten children in the main ward and one more isolated in a separate cubicle. Three post-tonsillectomy children left at 11am and there was a good deal of movement around the ward as doctors and nurses checked them before their parents took them home. They, like all the other children, except one, were up and about. Four of the children would be there all day and it is of interest to see how their time was spent. Despite its architecture the ward was a cheerful place with pictures on the walls and plenty of toys lying around on windowsills, tables and even the floor. John was a lively little boy who was 5 years old. This was his eighth day in hospital with a chest infection. He and his friend Andrew wandered around the ward looking for something to do. A wet flannel caught their eye and John with an engaging smile picked it up and threw it at two 4 year olds who were sitting at the table: the boys had a drink before joining a small 4 year old girl who had a pack of animal cards. In a very few minutes John was off to join a nurse who was reading to another 4 year old. Within 10 mins he ran off to join another nurse who was helping a

Table 4:5 Ward A. Occupations of Children (Mornings)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
9	9(0)	126	26	100	10	26	4	20	14	---
6	5(0)	70	20	50	19	20	6	8	50	tutor
5	5(0)	70	13	57	15	22	11	6	46	---
7	7(3)	98	7	91	16	18	9	20	27	---
11	11(0)	154	36	118	26	24	3	18	25	tutor
Totals										
38	37(3)	518	102	416	86	110	33	72	29% avg.	

Table 4:6 Ward A. Occupations of Children (Afternoons)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
6	6(0)	78	8	70	14	17	6	14	29	---
4	3(0)	39	7	32	4	11	7	2	34	---
7	6(0)	67	21	46	4	17	2	8	13	---
4	4(0)	52	26	26	7	14	8	8	58	tutor
7	7(1)	91	13	78	36	14	10	19	59	---
Totals										
28	26(1)	327	75	252	65	73	33	51	39% avg.	

small boy with a Mr. Men puzzle. This completed, the nurse went off to fetch another puzzle but John did not care to wait. The nurse reappeared and he joined her but soon left to pick up a car which was on the table by the model garage. Next he was to be seen under a bed with 4 year old Ronnie. They chatted, bouncing on and off the bed sometimes picking up a piece of paper and drawing. This continued for half an hour. Ronnie decided to play trains and in and out they went under beds and tables round and round the ward. At 11.30am nurse turned on the t.v. and John took a front seat. Nothing showed on the screen and so he went off again saying in loud tones that he did not want to watch. Nevertheless he soon returned and sat watching a very adult programme.

In the afternoon John's mother visited. For a while he worked on his puzzle book and then lay down for ten minutes. The t.v. took over and he sat happily in front of the set munching a packet of crisps. Some smoke breathing dragons appeared on the screen and he rocked back and forth hectically as they pretended to do battle. The song 'Old McDonald has a farm' followed and he climbed on his mother's knee and they swung in time. A new 'old patient' entered the ward and soon the two 6 year olds were having a rough and tumble game. The programme continued but both boys complained loudly of boredom. Back and forth to the set until at 3.15pm John picked up a Rubik cube which he turned round and round.

Eric and Michael were in bed on opposite sides of the ward. It was Eric's third day; he was 10 years old and had an orchidopexy. He looked both sick and bored, but his mother arrived and he picked up his Rubik cube and twisted it round and round while he chatted to his mother. He got out of bed and looked around aimlessly before returning to bed and to sleep. He woke up before lunch and picked up the cube. After lunch he was to be seen once again turning the cube but not in any purposeful manner. His mother left. The others were watching t.v. but he couldn't see it as

it was at the far end of the ward. He looked upset as he tried to see. A nurse noticed that he was unhappy and came to chat. His Mum returned but despite the plentiful supply of games and toys he turned the cube in a totally haphazard fashion for the rest of the afternoon.

It was Michael's 4th day in bed following a skin graft. He was 8 years old and looked halfheartedly at a book and then picked up 'Simon'. He played with this electronic musical toy for a few minutes before starting to draw a picture. Soon he picked up 'Simon' again and was joined by an 11 year old 'tonsils' boy. Michael's mother arrived and he showed her his drawing. He was fond of drawing and they settled down to a drawing game together. The ward became very noisy as a child screamed and was sick and Michael watched fascinated. He then returned to playing with his 'Simon' but this time, like Eric with his cube, it did not hold his attention. He was very pleased to see more visitors, but they went and he reverted to his music box. As the afternoon began he was to be found with a dolls' house but for some reason it annoyed him and he thumped it hard. Two nurses were chatting nearby; they ignored him and he continued to thump it for 20 mins. The t.v. was turned on, but like Eric he was annoyed because he could not see it. He complained of itching and sat moaning, but when 'Old MacDonald's Farm' started, he joined in. He could hear the story which followed but it was very short. His mother soon arrived bringing crisps and he spent some time munching and chatting. At 3 o'clock he picked up the cube, soon tired of it and picked up a posting box. A 6 year old joined him to play for the last 20 min.

The fourth child was quite different. Alison was 10 years old and in for tests. She was a serious little girl and would be happy reading. Despite fingers in her ears a small girl kept interrupting, and when she went away the nurses kept chatting. In the end Alison retreated to her bed. The nurses followed her there, so she gave up and flicked the rubik

cube and joined the jigsaw puzzlers. Then she did manage to escape to her book. Her mother appeared and they had a good game of 'Connect 4'. The last 20 mins were spent with a puzzle book. Two nurses joined Alison after lunch - young nurses related very easily to these quiet intelligent children. T.V., games and a puzzle book kept her happy while her mother chatted. At the end of the afternoon a man with the full gear of a motor cyclist (possibly her uncle) strode down the ward and Alison was the delighted recipient of several presents.

What else of interest to the observers happened that day? That afternoon William, aged 6, returned as he did every few weeks and he immediately helped the ward cleaner get the tea. The ward cleaner has spent a lot of time talking to children. After tea during the t.v. when the programme got exciting he was the one to fall backwards off his chair. One child had been isolated and he was the only one besides Alison to sustain a game for 20 mins - this was an electric game with clowns which he was playing with a nurse.

Was this day to be typical of all five? On the second visit a tutor arrived for John the 5 year old who was frequently away from school. She sat by his bedside and played counting and reading games. She read to him and he to her. All around children were cruising about, picking up games starting to play with them and leaving them for something else. Other children just lay in bed waiting. It was not easy for John to concentrate - he was only 5 years old. The tutor stayed for seven sessions and then his parents arrived. Richard and all the others watched fascinated at the commotion caused when a child fell off his bed and then went to fetch 'Action Man' from the toy cupboard. In the afternoon he found some toy soldiers and with his mother as companion he went out for a walk.

On the third visit there was a severely mentally handicapped child of 8. A music box kept him happy for a very few minutes and his mother

chatted to him when she arrived. All the afternoon he just lay. An attempt was made to give him a toy but it failed. The other children ignored him. Sister was not on duty and the ward appeared unusually tidy. Only one game was out on the table - the garage which did keep several boys amused. The toy cupboard however was locked and the constant visits of the children to fetch new toys did not take place. The atmosphere was less warm than usual and a new admission sat alone looking very sad. Only two children ate any tea. However three of the children were quite busy crayonning printed pictures.

Day 4 and the tutor arrived for John who was present on day 1. His parents played cards with him in the morning and the tutor had him working for 7 sessions in the afternoon. Two games intermittently occupied the other 6 children, three of whom were aged 4. The first was a fire station and Theresa liked to wind the handle round and round. The other game which was passed round and round was a water game. Inside a plastic box full of water coloured rings appeared in the water when a button was pressed. It kept Nicholas amused nearly all the afternoon.

Day 5 and the ward was crowded with eleven children, only one of whom was less than 5. David aged 7 with a fractured femur would be off school for 10 weeks and had a tutor for 1½ hours, but for the rest it was a dreary morning. A model railway was on the table but except for playing with 'Simon' the children settled on nothing. But in the afternoon the position changed quite dramatically and the ward came to life. There were 7 children aged 4-9 and a nursery nurse took charge. David's tutor had brought in 'Hansel and Gretel' and this she read to 5 children at the table and included David who was in bed. Despite the very loud conversation going on among the other nurses this and further stories kept the children's attention riveted. This nurse, Nurse X, then talked with all the children about the hospital day and how they spent it. Four nurses

joined the group and Nurse X read "Chicken Licken" giving each child a part in the story. David and a Nurse joined in from his bed and the Staff Nurses watched fascinated. Even the ward cleaner joined the game and each was involved with a child as 'Ducky Lucky', 'Goosey Loosey', 'Turkey Lurkey', etc. All looked happy and involved. All the children ate quantities of tea except one who had had her tonsils removed. Her mother said 'Eat up or I'll go home'. Tears followed. Nurse X went to help and said 'Every time you eat you get a little better'. All the tonsils children then made more effort to eat. Finally Nurse X encouraged David to draw a picture and most children completed the afternoon playing games or colouring pictures.

As the picture of life on this ward developed there were one or two surprises. Very little t.v. was in evidence but a lot of time was recorded as 'chat' to parents and staff, mostly junior nurses or the ward cleaner. Games were usually only sustained if an adult was involved and it is interesting to see which adults were involved (table 4:7).

On three occasions a tutor appeared for an individual long stay child (5 hours a week of individual tuition was permitted). Parents sometimes read to their children but more commonly helped them draw pictures or write in puzzle books. The longest period of interaction (27 sessions) was sustained by a nurse who on the 5th afternoon took on a nursery teacher role. Only once did a nurse play a continuous game with a child and parents who might have been expected to play games with their children in hospital only sustained 35 out of 668 sessions.

The ward was very crowded especially when visitors were present. Most children were together in one room and there appeared to be more socialising between children than on any other ward the Observers were to visit. Thirty-five of the forty-three children were mobile and there was constant movement. Nurses were often present on the ward as the nursing

Table 4:7 Ward A Adult Interactors with Child's Work or Games (sustained)

Day	Possible 10 Min. Sessions	Read Work Workgames	Adult Interactor			Continuous Games	Adult Interactor		
			Tutor	Parent	Nurse		Tutor	Parent	Nurse
1	170	24	0	8	7	10	0	4	2
2	82	23	8	4	5	13	0	11	0
3	103	19	0	4	0	13	0	4	0
4	117	23	5	6	0	17	0	6	0
5	196	62	9	13	27	13	0	10	0
Total	668	151	22	35	39	66	0	35	2

station was very small. However despite the number of toys available and the number of adults present it was only when a nurse took on the role of a nursery teacher that sustained activities occurred. On the afternoon when the ward Sister was away, only one toy, a garage, was brought out. The children were very bored and only 2 out of 6 ate any tea. In contrast, when a nurse acted as teacher not only the children but the other nurses and the ward cleaner joined in and the enjoyment of all was obvious. From the Observer's view the ward came to life. The activities of reading, talking, playing word games and drawing were typical of an infant school and they were not attributable to special equipment or helpful environments: they were undertaken despite the unnecessary interruptions of other adults. On this occasion all the children ate their tea, even those who had recently had their tonsils removed.

Every session except for the last received a comment by the Observer 'The children appear very bored.' It was not that they were overtly unhappy but that despite the goodwill of all concerned and despite the usual availability of many toys, without a leader the children were unable to pursue or sustain any occupation.

Ward B

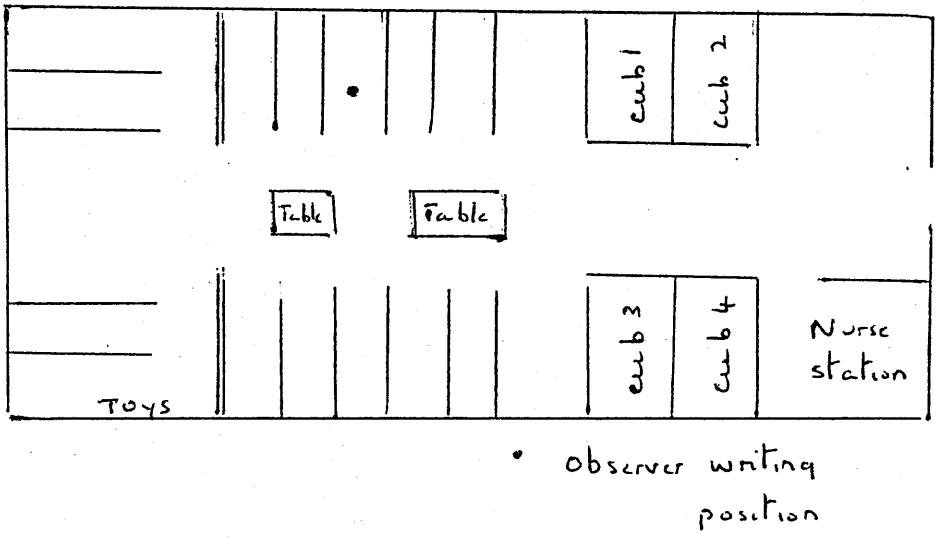
The design of ward B was not dissimilar to A but it held 18 beds, seemed much more spacious and had a garden. Few toys lay around though some were available at the end of the ward. An empty bedside proved the most inconspicuous site for the Observer. The teacher and her assistant made it clear that they would be too busy to converse during school - indeed this was the case and it suited the purpose of the investigation. In the afternoons there was no teacher but usually a playleader. (The playleader did not appear in the mornings and it was assumed that she was with the under 5's in the playroom or elsewhere.) The nursing staff paid

no attention to us and unlike the first ward we felt ourselves to be no part of it. Previous to our visits the bed occupancy had been high but numbers then became low for the next few months. Tables 4:8, 4:9 shew the occupations of children on ward B in the mornings and afternoons.

The teacher on this ward worked with an assistant who attended to those aged 7 and under. The teachers would appear on the wards at 9.10 am pushing a large trolley filled with pens, pencils, paper, games and equipment. There were locked bookcases on the ward and these contained a selection of books including books of a general interest. The children who were mobile came to sit at two tables. The younger children might be given English workbooks e.g. 'Ronald Ridout', Maths workbooks or Beta maths books, puzzles, matching games, pictures to colour or jigsaw puzzles. There was a break in the middle of the morning and it was noticeable how the children continued in the absence of their teachers and they were still quietly continuing at 11.45 am. The teacher went from one child to another constantly listening to reading or helping with sums. The older children spent more time planning work with the teacher sometimes using their own school books. On more than one occasion a decision was made to concentrate on Art because the child was not feeling at all well. When the mobile children were settled the teacher offered books, puzzles and workcards to those in bed and thus all were involved. Everything to do with school was neat and orderly and quiet and teachers were always busy with a good deal of communication between themselves and the children, although it was not possible to hear what was said.

The nursing staff kept a low profile, taking temperatures and making observations when necessary. However if a child was needed by a doctor or by a nurse for a dressing, often the child was summoned without a word to

WARD B



Staff

1 teacher
1 nursery Nurse asst. (p.t.)
1 playleader

Children (not infants)

Visiting
Open

18 Beds

Age Range Observed

4 - 14 years

the teacher. Sometimes this scared the child and it did not seem to be in the interests of any of the adults. Physiotherapists on the other hand always interceded with thoughtfulness. This was to be the pattern on all three wards. It seems likely that this was not deliberate rudeness on the part of the medical staff; rather that they were not aware of the importance of the school to the child.

Table 4:8 Ward B Occupations of Children (Mornings)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
4	4(0)	56	3	53	53	0	0	0	100	teacher*
7	6(0)	84	15	69	64	0	0	4	93	teacher*
9	7(0)	72	7	65	61	0	0	1	94	teacher*
8	8(0)	112	7	105	97	0	0	2	92	teacher*
5	4(0)	52	8	44	35	0	0	8	79	teacher*
Totals										
33	29(0)	376	40	336	310	0	0	15	92% avg.	

* classroom assistant present

Table 4:9 Ward B Occupations of Children (Afternoons)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
4	4(1)	52	7	45	3	36	34	12	82	play leader
5	4(0)	52	10	42	12	16	4	2	38	---
9	7(0)	91	31	60	1	45	28	7	48	play leader
8	8(0)	104	23	81	18	34	24	8	53	play leader
Totals										
26	24(1)	299	71	228	34	131	90	29	54% avg.	

One week a mother commented how marvellous the school was for the children in the mornings because as the playleader was on holiday there was nothing at all in the afternoons and the children were just lying around. A quiet hard working atmosphere always prevailed and out of 35 children who were present during the visits, three will be considered in some detail.

Betsy was an attractive teenager who had been in hospital for 5 days with diarrhoea and vomiting. A strong protest about having to go to school in hospital might have been expected; however the teacher had discovered Betsy was interested in butterflies and had given her a book about them. She looked for a good picture to copy but felt sick and retired to bed. She soon returned to carry on with her picture. While she drew, the teacher talked to her about school work and discovered that she had missed some French lessons. She found a French textbook and together they completed an exercise. Coffee time came, but the picture continued for the rest of the morning. Other children joined in making nature pictures with the help of books from which to copy. At the end of the morning the teacher amalgamated them and put the result on the wall where it joined others of a similar style. There had been a good deal of chat between teachers and children but no laughter or messing about. Rosemary aged 10 on her 5th day following appendicectomy spent 1/2 an hour on an English workbook and the next 15mins on a B/4 Maths book before copying a detailed drawing of a mouse. Then her mother arrived and supervised her letter writing. Finally at the request of the assistant teacher she made a birthday card for the playleader. The pattern for the younger children was almost always the same. There would be an English workcard or book or matching pictures or puzzles, followed by number work out of another workbook or textbook. An attempt would be made to find the right level, it was not always easy: Martin(7 1/2) for example was offered and

accepted take away sums but was then found to have problems in addition up to 10. Reading to the teacher and by the teacher was normal and there were lots of jigsaw puzzles, map puzzles in particular being popular with older children. Art work usually involved copying and colouring and took up a good deal of time. It was usually undertaken after the more formal work but there was no rigidity; it could precede it.

In the afternoon Betsy played cards with two nurses while Rosemary, Martin and three more nurses played monopoly which lasted nearly all the afternoon. The playleader arrived on the ward at 2 o'clock with a trolley full of toys and games. These included a model farm, a toy medical box, 'Battleships', 'Goose Game', Chess, Mastermind and jig-saws. Betsy's card game ended at 2.30pm and then she took care of Rachel a small 3 yr. old who had been a regular inhabitant of the ward from birth and who was a great conversationalist. On another afternoon there was considerable amusement because the ward clerk entered the ward and said that she had been telephoned in her office by Rachel but where was Rachel? A hunt ensued and Rachel was found at the desk in Sister's Office happily glued to the telephone and continuing in conversation. Towards the end of the afternoon, one of the four nurses exclaimed that the ward was far too quiet and turned on the t.v. No one was interested and the nurse soon left the ward with the programme continuing to cheer us up!

That afternoon contrasted strongly with another when the playleader was on holiday. There were 5 children on the ward and 3 nurses or nursery nurses in training. Thirteen year old Frances spent most of the afternoon chatting to a nurse but the rest changed their occupations constantly. On another afternoon the number of games sessions was particularly high - monopoly, battleships, lego, mastermind, noughts and crosses, kiddy snap, painting, table football, jigsaws, cards, cat and mouse and play with a toy garage were all undertaken for a few minutes. However the playleader

settled to playing 'Mastermind' with an older 12 yr old girl and without adult interaction few of these games were sustained. This was a common predicament for both teacher and playleader. To play with one child could mean deprivation for others. The most interesting afternoon occurred when Steven aged 8 and an asthmatic was present. The morning had gone well as Dick (aged 13) had set a good example by working hard at Algebra and so Steven had settled to Fletcher Book 2 (His own school work). After an hour he changed to an English workbook and learnt some nouns and verbs with the teacher. All through the coffee break the children kept going but unfortunately Steven's mother had corrected his English wrongly - a dilemma for the teacher. His mother asked if all children of his age read books like he did - 'Jaws'. He had been fascinated by this book and now when he drew a picture for the teacher there was yet another very realistic shark with blood all over it. All over the bed of this seemingly extrovert little boy were notices which said 'Keep out - Dangerous Bears' or 'Keep out - Dangerous animals'. In his bed was a huge toy lion which his mother said looked after him and helped relieve his anxiety. He did not put these notices on his bed at home.

The afternoon was of considerable interest to the children. First the window cleaner had a tall ladder in the ward and he pranced up and down like Charlie Chaplin on a film set. Then Paul suggested to Dennis, both aged 6, that they should play 'doctors'. Rhoda aged 13 fetched a stethoscope for Diana aged 12 who was diabetic and pretended to be a war reporter. The girls discussed injections before drawing the curtains against 'those noisy boys' in order to have a game of battleships. Then the Playleader arrived with 'Playdoh' and 7 children including Steven spent a blissful halfhour making cakes. So involved was Paul who had now been in hospital for a week that when his mother and grandmother arrived, he asked them why they had come and ignored them. Thirteen year old Derek

had gone off to the rather distant playroom to watch t.v. on his own. After a doctors' round the doctor play recommenced. The playleader produced masks and the girls rejoined the group. The children put a large Mickey Mouse on traction and bandaged up a Teddy. 'Nurse Attention' was written on a notice and the following remarks ensued; Diana in a nurse's cap "I think he's died". Paul "I think a little blood test will do. You do your own with stuff inside?". Diana "Yes". Paul "Goodbye, that should do". Paul stared in Teddy's eyes. Then 'Nurse' Rhoda said she would go and the younger ones should look after the animals. The younger children packed up the doctor's bag and proceeded to reexamine all the animals.

The mornings spent on this ward had shewn a complete contrast with those spent on ward A. The presence of the teachers had meant that all the children on the ward had participated in near normal school occupations. These included four children who had remained in bed. Children had made relationships with the teachers and had been able to concentrate on their studies. A few parents had appeared and most had encouraged their children to participate. Nurses took observations on the ward from time to time and the teachers had joined them for coffee in the middle of the morning. The children's occupations had been almost totally traditional and although there was a great deal of Art, there was no attempt at Science, Cookery, Drama or Projects. This is not to say that they were not undertaken sometimes but that they did not happen during the course of the visits. There was no work connected with the hospital and games except for school work games were not played in school time. The children were occupied for almost the entire morning and the type of occupation should be noted: 'W' and 'R' on ward A without a teacher usually referred to colouring printed pictures or reading comics or puzzle books and on ward B it represented reading school books. On the other hand a larger than usual proportion of school time was spent on Art, but this did

replace P.E., Music, and a number of other subjects normally on a curriculum.

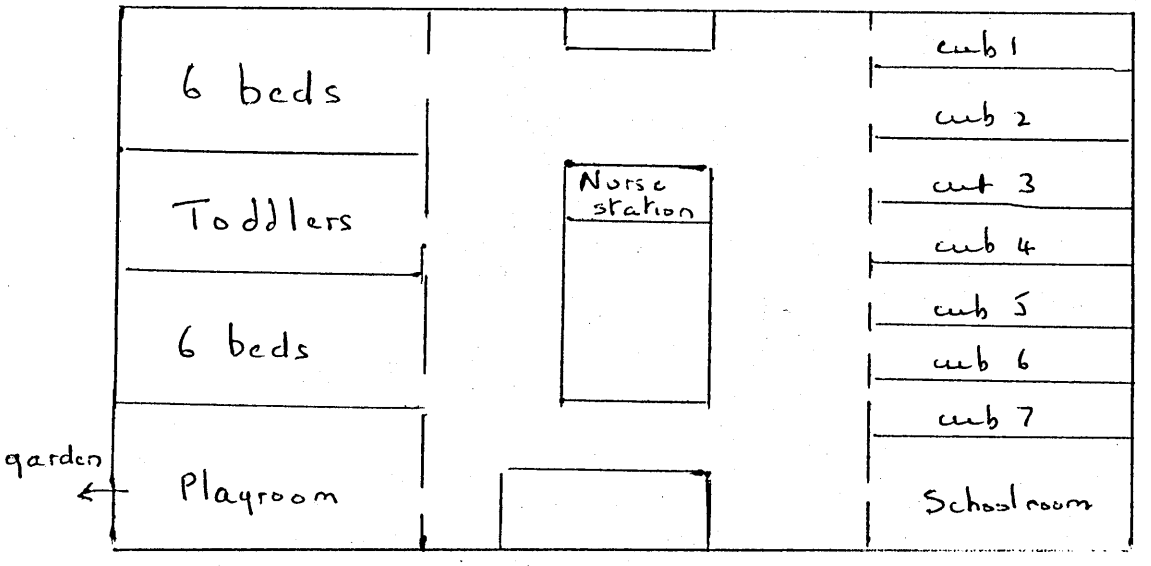
On the days with lower % occupancy, the Med, etc. time was greatly increased due to the presence of post operative appendicectomies. The unusually high occupancy rate of the first afternoon was due to there being four interacting nurses combined with the playleader and only four children present. On the second afternoon there were nurses available to play with the children but without the stimulus of the playleader little happened. The imaginative and involved play of the 4th afternoon was similar to the experience on the last afternoon of ward A.

As on ward A, the presence of the children in one room made the organisation much easier for the teacher. The ratio of mobile to immobile children was about the same, 27:7. An assistant teacher meant a high staff ratio and the usual nurse presence freed the teacher from having to keep too close a watch on the children's medical condition. The children were not bored when the teacher was present and even those immediately postoperative appeared to wish to join in. The continuation of work during the coffee break in the absence of the teachers was an indication of absorption in the activities. The work itself was traditional with a fairly lengthy amount of time being spent on tracing pictures. The teachers did not see their role as explaining the hospital environment and any hospital play was encouraged by the playleader in the afternoons. The mornings on A and B were totally different but the afternoons when playleader or nurse took charge were similar.

Ward C

The next ward, ward C, was to be different and because of its geography more difficult to observe.

WARD C



Staff

1 teacher (pt)
1 art teacher 2 mornings (additional sessions during study)

Children

19 beds (school age)

Visiting

Open

Age Range Observed

6 - 16 years

*Observer was constantly on the move and often wrote at the nurse station

What difference would be seen on ward C? The geography was more complicated. School age children could be found in two ward areas in the playroom or, in the schoolroom or in any one of 7 cubicles. On four of the 5 days two teachers were at work, and sometimes in addition the playleader was to be found with a school age child in addition to the 4 yr olds. (Extra teaching was allowed because of a 15 yr old boy and a chronically ill 13 yr old girl.) This occurred either when an older child was barrier nursed (isolated but could usually be visited by an adult wearing a mask and gown) or was a very sick recurring* patient.

The same hardworking atmosphere prevailed as on ward B. One teacher took all possible children in the schoolroom which had a door. The room

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* A recurring patient means one who is readmitted one or more times.

Table 4:10 Ward C Occupations of Children (Mornings)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
9	9(0	126	8	118	98	6	0	3	83	teacher*
6	6(0)	65	6	59	51	0	0	5	86	teacher*
12	7(0)	98	13	85	76	0	0	2	89	teacher*
6	5(0)	65	15	50	44	0	0	8	88	teacher
7	7(0)	98	13	85	84	0	0	0	99	teacher*
Totals										
40	34(0)	452	55	397	353	6	0	10	89% avg.	

* second teacher/tutor present

Table 4:11 Ward C Occupations of Children (Afternoons)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
9	6(0)	78	37	41	15	13	7	9	54	play leader
5	5(0)	65	21	44	3	8	4	15	16	---
12	7(0)	91	23	68	27	9	5	9	47	play leader
5	4(0)	52	6	46	12	4	3	10	32	play leader
7	7(0)	91	15	76	15	12	7	18	29	play leader
Totals										
38	29(0)	377	102	275	72	46	26	61	36% avg.	

was small but it was full of books and interesting pictures and looked like a real schoolroom. One day 5 boys aged 6½ - 9 yrs spent a busy morning with Alpha Maths Book I, followed by duplicated English worksheets. At break one of them managed to persuade Lawrence, aged 8 with muscular dystrophy, to join them in his wheelchair. Both the teacher and ward sister had failed to persuade him to go to school earlier. 'Word Perfect' English Spelling came next; then children chose books to read and jigsaw puzzles came out at the very end. Even Simon, who was not much of an attender at his own school and that not because of illness, was persuaded by the common work ethic to have a go at some workcards. Jessie had to stay in bed on the ward and a second teacher supervised her while teaching James her own special pupil, a severely handicapped boy of 15 who had been in hospital this time so far for three months. He was quite unable to concentrate without a teacher and often avoided school altogether. James was very popular with the nurses and chatted easily to them.

Another morning there was only one teacher, and Maria (9) who was on the ward wanted to paint but couldn't because the teacher was in the schoolroom with two boys and a girl. Alan made a map of New Zealand and then read and wrote about Apollo II, while Matt was fascinated by insects and the teacher gave him a book and a question sheet. This led to a very interesting discussion of scorpions by all. Madeline had been a patient for 9 days and traced a picture of a Welsh girl and then read a book about Wales before answering a workcard. The morning ended with Pelmanism using cards representing aspects of the calendar.

The work schedule was varied. Mental Arithmetic cards, Alpha/Beta or Maths workcards were offered to short-stay children. Of two 9 yr olds present one morning Miles began by printing with a leek and then reading a book, while Joe did money sums. The latter complained that the door was open and the babies were disturbing him'. Then Miles retired to bed with

an English workcard while Joe drew a battleship and invented a story which he told to the teacher before writing. Both boys ended the morning doing map jigsaw puzzles.

The Observers were present for two art mornings when a special Art teacher was employed. The very large pictures of the seaside, butterflies, space, castles, soldiers and others which were hanging all round the corridors made an immediate impression on all who entered the ward. The pictures were inspired both by the art teacher and the playleader. One art session consisted of three children being utterly absorbed each making a toy village to their own design out of paper and peopling it with pipe cleaner figures after painting it. This activity was discussed and admired on and off all the afternoon. A second session was with shells and took place on the ward. The subject was the seashore. Martha with a severe metabolic disorder and Mary with a blood disease were fully absorbed. Often Martha could not undertake any activity but today she enjoyed a story. Mary wrote a story about mermaids to go with her seaside model. When the other children had been summoned to admire Martha's crabs, Desmond who had not made a model decided that he too would like to write a story.

Martha had some very bad days and on those occasions the playleader sometimes took over. One day she spent a large part of the morning helping this 13 yr old girl make and play with a play-mobile ambulance and doctor's set.

The mornings, then, except for James' evasion of school, were good. The afternoons were boring as the playleader said that in general she felt no responsibility for the older children except to give them games if they wanted them out of the cupboard. Table 4:11 shows clearly the lack of continuous games sessions. The high number of reading sessions occurred when the children were lying on their beds reading comics. One

afternoon the only sustained game played was by two boys, one on a bike and one in a wheelchair chasing in and out of ward and garden until told off by the nurses for making too much noise. 'Beryl the Peril',a comic style book,was the most advanced reading on the ward. One afternoon Anna was distressed and sucked her thumb staring out of the window. The nurse saw the Observer and told her that Anna was missing her parents who had just left and she would play with her. Two boys were sitting on their beds nearby discussing suppositories with a mother, when the doctor arrived to do a blood test on Anna. Afterwards Anna explained that that was why she had been crying but it was not so bad. Nurse had to leave suddenly and the sobbing started this time for her Mummy. On this one occasion it seemed neccessary to comfort the distressed and leave the writing. There were plenty of nurses about and one after the other they chatted to James, but no one attempted to do anything with the other 6 very bored children.

This ward had provided a more complex situation with children widely scattered but it had also provided a schoolroom with a door. This was very effective when there were two teachers and one could remain on the ward. As with ward B, the work occupation rate of about 89% was very high. During the visits, children spent more time on Mathematics and spent time writing stories which they had not done on ward B. The level of Art teaching seemed to help the general creativity of the children. The interest of a very sick patient when the seaside model was suggested was indicative of the value of the stimulation afforded. In addition the universal interest in the model villages made by the children added to the aliveness of the whole ward. Creativity as well as normality was important for the children.

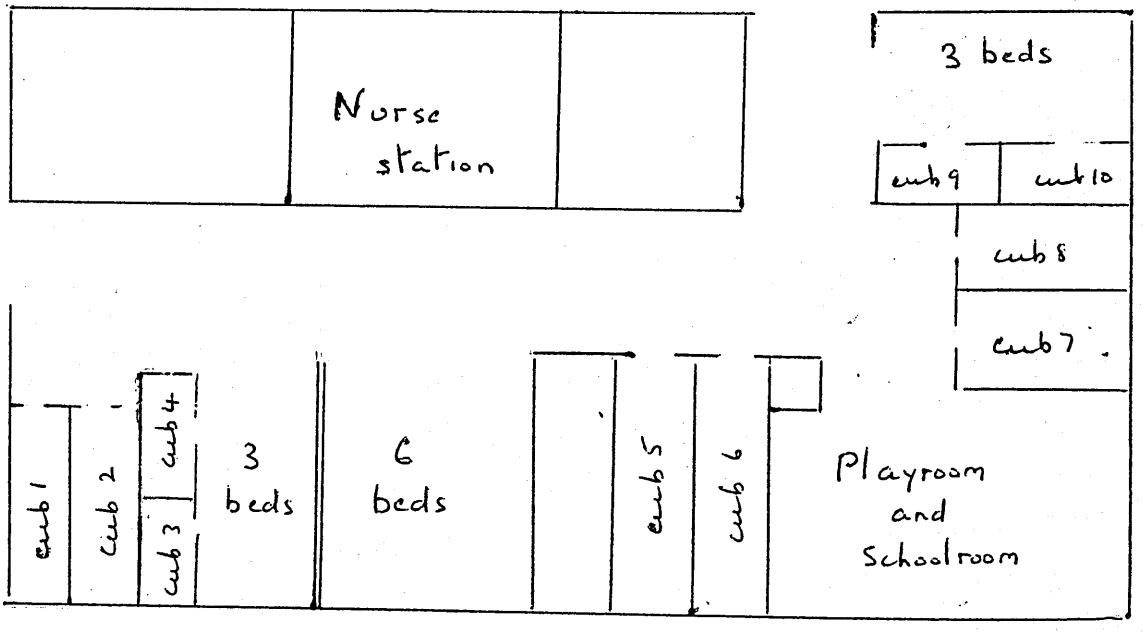
In the afternoons the playleader was only employed until 3pm and her role with children to be found in so many places was obviously difficult

and during the study she was seldom seen with schoolage children. The general atmosphere was warm and welcoming and there were plenty of young nurses in attendance. It is easy to surmise that a teacher could have brought the ward to life but it would have needed a person with the ability to gain the help and support of all concerned. It is to be seen whether ward D which had a teacher as well as a playleader in the morning and afternoon was more or less successful. Tables 4:12, 4:13 shew occupations of children on ward D in the mornings and afternoons.

Ward D

The geography of ward D was even more difficult for the Observer. Children of school age could be found in 3 different ward areas and 10 single rooms, a long distance from one end to the other. For example at 9.15 one morning Graham (9) was asleep in the first cubicle and Elisabeth (7) was in the first ward area while three children were in bed in the largest ward area. Ruth sat by the fish tank and Evan was already in the playroom. Janet (9) was being taken to X-ray and Hill (11) who was partially deaf and had had a colostomy was miserable in his own room beyond. Amy was 13 and had been scalded, so was isolated, and beyond all these Francis (long-stay aged 11) kept company with Joey who had not yet had breakfast. Other younger children also were around the ward, and on the way to the playroom was a dental patient who would be returning home within the hour. A teacher and assistant would, with the help of the playleader and the nurses, attempt to move all possible patients in beds, chairs, with drips and drains as well as those who were mobile into a large playroom. This was sometimes full to bursting as parents arrived and stayed to help and nearly always a volunteer assisted. On 'B' and 'C' school started at 9.10; on this ward it was an unpunctual 9.30. All children were included and if isolated were given equipment which enabled

WARD D



Staff

1 teacher (a.m.)
1 classroom assistant (a.m.)
1 teacher (p.m.)
1 playleader
volunteers

Children (not infants)
22 beds

Visiting
Open

Age Range Observed
5 - 14 years

them to partake in the same activities as the rest. The ward and playroom were full of wall pictures, both very large scenes such as 'Space' or 'Cowboys and Indians' to which the children had contributed individual items and small pictures and writing.

On one of the mornings there were three long-stay children one of whom, Ben (12), had had a previous recent long stay in hospital and a second, Janet (11), who had been involved in a shattering road accident with subsequent social problems. There was Alice (14) flat on her back because she had injured it and Henry (6) and Patrick (8), both with

Table 4:12 Ward D Occupations of Children (Mornings)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
8	8(0)	112	13	99	83	3	0	8	84	teacher*
7	6(0)	84	0	84	82	0	0	0	98	teacher*
11	10(0)	135	11	124	106	0	0	4	85	teacher*
5	4(0)	56	3	53	43	0	0	4	81	teacher*
13	12(0)	160	17	143	99	23	16	10	80	teacher*
Totals										
47	40(0)	547	44	503	413	23	16	26	85% avg.	

* classroom assistant present

Table 4:13 Ward D Occupations of Children (Afternoons)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
9	8(0)	96	11	85	64	5	3	0	79	teacher*
8	6(0)	78	7	71	45	9	6	2	69	teacher*
10	7(0)	63	10	53	42	12	4	4	87	teacher*
5	4(0)	52	8	44	30	5	5	2	80	teacher*
13	7(0)	91	16	75	33	28	27	4	80	teacher*
Totals										
45	32(0)	380	52	328	214	59	45	12	79% avg.	

* classroom assistant present

abdominal problems. A squirrel from the museum, which the teacher had borrowed, was on the table where the two younger children sat. The other four were in bed. Giles (9) and Ben spent 30 - 40 mins doing their own school maths with the help of the teacher. Giles then read and wrote about the squirrel until 11 while Ben got on with his own school history project. Janet was still considerably distressed by her accident but drew a picture and started to write a story encouraged by the assistant teacher. She started a word game and despite the arrival of a visitor continued with the teacher next doing a crossword. Henry drew the squirrel and then changed to Maths. He chose some easy addition sums but as he did not get them right the teacher suggested he played snap with the cards saying 'snap' when the numbers added to 10. He was very keen. Next he played a wordgame with his mother. Patrick, encouraged by his mother, drew the squirrel and while he waited for the wordcard he read 'Curious George goes to hospital', a book about a monkey who has to go into hospital and have a piece of jigsaw that he has swallowed removed! Alice had read this book before drawing the squirrel. She was able to draw by using a small blackboard which the teacher had propped on her bed. Next she started to write a story for the ward magazine - she wrote about her accident. She missed the t.v. programme at 11 to which all children and adults sat glued. A mother was filmed who, despite no hands, was undertaking the cooking and cleaning for her family by the use of her feet. Discussion followed. Giles and Ben had been bed-bound for a long time so now they had an energetic game with a ball throwing it to the teacher. They ended the morning with a card game suggested by the teacher. Meanwhile Janet was given 'Tilecraft', a shapes game, by the assistant teacher and Henry and his mother played a mathematical game 'Pirates Gold' and were joined by Patrick and his mother. They went on to use 'Speak and Maths', one of two electronic educational games available. Alice returned

from the doctors to the electronic spelling game. Despite the constant flow of visitors and doctors it had been as quiet a morning as on 'B' or 'C', but it was not always the case.

On the morning when there were 10 children involved in school, the mother of an immobile teenager bounced into the room at 11 o'clock and offered sweets to all the children. At the same time and in a very loud voice she told all of them about her annoyance over her son's medical treatment. It was not possible for the children to continue working in these circumstances so the teacher suggested to the mother that she would have more space and freedom to chat if she and her son moved to the ward. She was happy with this suggestion.

Day 5 saw 12 children, two of whom had had appendixes removed the previous day but were so involved in school that they were included in the study. Because of the number of children, school was late starting. More children meant more visitors and more chatting in school, and the Observer described as a shambles what happened at 11.10am. One doctor visited one child while a whole round of doctors squeezed in to see the very bad injury to the leg of another. A boy was wheeled out for physiotherapy and 4 boys were summoned to see yet another doctor. All these events occurred more or less at the same time and temporarily only 2 children remained in the room. To include all children and to use a playroom which had no door as a schoolroom inevitably compounded the problem for the teacher.

The happenings on this ward shewed even more clearly the position of the teacher in being able to produce a near normal school situation for 40 children, the majority of whom were immobile. The teacher had been involved unceasingly in making suggestions for interesting work, supervising children's own schoolwork and obtaining their involvement in activities which were sometimes related to the hospital (for example, on one

morning the children made a graph of how they spent their day in hospital), but more often were connected with the child's own particular interest. The presence of a classroom assistant had meant that recent postoperative children might be given lego or games but still be included as part of the school, and also some attention could be given to a child who was isolated. It meant that young children distressed by accidents could move in and out of the more traditional pursuit of reading and number to play, e.g. with a toy hospital. Their occupation time was the whole morning but their attention span for any one pursuit was limited. This could not have been undertaken without the help of the ward staff and the encouragement of the parents. In the afternoons a teacher was employed from 1.30 - 3.30 pm and sometimes the playleader came to support her from 2 o'clock onwards. If 4 year olds or younger children were present the playleader assumed responsibility. The teacher started by wheeling a trolley full of books and games round the ward because the playroom was used for ward reports and was not available until 2pm. At 2 o'clock the children were moved into school, quite often with parents in accompaniment. This left a rather short time for cooking, pottery and the creative activities that the teacher had planned and it was interrupted by the arrival of tea. Cookery was a very popular activity during which the children prepared and ate the most delicious cakes. The same children as had been observed during the morning of day 2 will be followed in the afternoon. It was a day for the girls to make felt toys and the boys Christmas decorations. Before 2 o'clock there was not much action. Janet made a card and Alice played with a Rubik cube. The teacher moved the children into school and gave out the sewing materials before helping cut out the puppets. The girls spent a very happy afternoon sewing, sometimes joking with the teacher and talking about their illness. Alice organised snakes and ladders and the afternoon ended with their playing with the

board between the beds. Ben and Giles were together chatting in the ward before being pushed into school. The teacher shewed them how to make decorations for the windows. Giles was colour blind,or pretended to be so, which caused some discussion. A nurse and a nursery nurse helped them most of the afternoon but Giles grew tired of decoration making and asked the playleader for the doctor's set which she gave him. It was Giles' second long stay in bed and he was shewing his frustration by doing his best to annoy the nurses! The boys gave pretend injections and then discussed anaesthetics with the teacher. Ben did not notice the arrival of his visitors but reverted to decoration making while Giles read 'Pinocchio'.

Ron had been admitted to the ward just before lunch and was delighted to find there was clay in the playroom. He made a pot, had some tea, and then fetched a box of lego. Matthew played happily in the playhouse and then had a game with the playleader before he made a pot. However he didn't settle to anything for long and was perhaps missing his mother who had had to go home. It was an afternoon much enjoyed by the children.

Day 3 (afternoon) the ward sister involved the teacher in a discussion about Christmas and the children started school half an hour late. Older children like Ben were not always present at school in the afternoons. It was an accepted policy to leave them if they so desired and,on day 4, Zoe's mother decided she should spend the afternoon watching t.v. and so she was not included in the study. Mothers were sometimes very protective and Wilfred's mother sat beside him one afternoon totally silent but making contact by anyone else impossible. That afternoon when so many had been present in the morning, the two appendix children, the two with broken arms, and one with a head injury rested and slept all the afternoon. Nevertheless 7 children were present and had a busy and happy

time with the clay making items for a ward sale which was to be held the next day.

The afternoons were a generally relaxed and sociable time. Often hospital play took place. Janet was very imaginative and besides playing hospital scenes made up stories. One afternoon she balanced playing cards on the bar of her bed and said "It's so great it's going to get some confetti. Look 14 people up there, so I'll give them confetti." She tore up pieces of paper while the nurse brought milk and with a fine feeling for words said, "Milk with a totally tropical taste'" Milk finished, she threw the confetti and said "All of them getting married to each other."

By chance during this study the number of children on D was higher than on B or C. The problems created by the geography and by the immobility of the children possibly accounted for the later start in school. The occupancy rate was much the same in the mornings but the nature of the occupancy was very different. Few children used workcards and very few copied pictures. They wrote stories, drew imaginatively and used modern equipment which was especially appreciated by the more severely ill. There was more confusion from doctor's rounds but nurses, parents and volunteers assisted in school to a much greater extent.

The timing of afternoon school was not conducive to sensible planning since the teacher could not occupy the playroom till 2 pm. What did emerge was the pleasure of the children and adults, including nurses, in creative activity such as cooking and potting. The social interaction and experience was to the great benefit of the children. So far this study has been concerned with the patterns on individual wards. A comparison will now be made of the activities of the children in the mornings when the teachers were and were not present (table 4:14).

It can be seen that the positive occupations of children with teachers present was about three times that when they were not present. A

Table 4:14 Mornings - Occupation of Children by Wards

No. of Children	Possible Sessions	Read/Work Workgames	Chat	Continuous Games	% Time Positive Occupations	Ward Staff
9	100	10	20	4	14	
5	50	19	8	6	50	
5	57	15	6	11	46	A (no teacher)
7	91	16	20	9	27	
11	118	26	18	3	25	
Total 37	416	86	72	33	29% avg.	
4	53	53	0	0	100	
6	69	64	4	0	93	
7	65	61	1	0	94	B (teacher)
8	105	97	2	0	92	
4	44	35	8	0	79	
Total 29	336	310	15	0	92% avg.	
9	118	98	3	0	83	
6	59	51	5	0	86	
7	85	76	2	0	89	C (teacher)
5	50	44	0	0	88	
7	85	84	0	0	99	
Total 34	397	353	10	0	89% avg.	
8	99	83	8	0	84	
6	84	82	0	0	98	
10	124	106	4	0	85	D (teacher)
4	53	43	4	0	81	
12	143	99	10	16	80% avg.	
Total 40	503	413	26	16	85% avg.	

Summary

Positively Occupied	No Teacher	29%	
	Teacher	88%	

high number of 'chat' sessions was recorded on ward A and these will be presented in more detail. Also it will be observed that more sessions of 'Involved Games' took place on ward A, but these took place when parents were involved: they were seldom sustained when no adult was present. The teachers achieved an average occupancy rate of 88% which belied those who consider that children in hospital are too ill to benefit from their presence. On ward D in particular, children in pain following injuries were stimulated to undertake activities in an atmosphere of learning from which boredom was eliminated. The involvement of seriously ill children such as those with cystic fibrosis, spina bifida or cancer with their contemporaries who were less ill took place readily when teachers were present and the assumption that school was for all children was seen to be a powerful concept. As 'chat time' was not negligible on ward A, the chat sessions for all wards are reviewed in table 4:15.

Table 4:15 Chat Sessions (Mornings)

Ward	Chat Parent	Chat Nurse	Chat Adult	Total Chats	No. of Children	% Children Who Chatted
A	54	2	16	72	37	65
B	12	3	0	15	29	24
C	10	0	0	10	34	15
D	20	1	5	26	40	30
Total	96	6	21	123	140	

A review of the 'chat' sessions shewed that in the mornings almost all 'chat' sessions were between parents and children or visitors and children. Nurses were minimally involved. The last column shews that only on ward A were many children found to be chatting at all. The Observers

had coded 'chat' whenever parents had sat beside a child who had no other occupation - actually overhearing conversations was not possible. Thus while it is tempting to assume that visiting sessions, which was what 'chat' really recorded, were always positive; in reality parents were often bored and ill at ease in a strange environment. They often did not know what to do with their children and were to be seen reading women's magazines or doing their knitting. If the teacher asked for their help, they often seemed pleased to have an occupation. For this reason the chat sessions have not been included in positive occupations of children. If they had been included, they would on average represent 7% of children's available time. The playleaders did not appear very frequently in the morning studies but in the afternoons on two of the wards the children looked to them for interesting occupations. A teacher was present on one of the wards; would the situation be different if there was a teacher as well as a playleader? Perhaps the nurses might have more time to chat to the children in the afternoons or perhaps there would be so many visitors that the children did not need either playleaders or teachers. Table 4:16 shews how the children were occupied. It will be seen that one of the playleaders was not employed after 3 o'clock on four of the afternoons.

There was a difference: 29% occupancy with no teacher or playleader, 50% occupancy with a playleader and 79% occupancy with a teacher. On one day there was a high rate of 88% with the playleader on B and this was because three junior nurses joined the playleader to occupy 4 children, but this was exceptional. On ward C the number of involved games was very low and the moderate occupation rate was due to a number of children being occupied in reading while lying on their beds. The number of 'chat' sessions was much greater and these will be examined in more detail (table 4:17).

Table 4:16 Afternoon Occupation of Children by Wards

No. of Children	Ward	Possible Sessions	Read/Work Workgames	Chat	Continuous Games	% Time Positive Occupations	Ward Staff
6	A	70	14	14	6	29	
3	A	32	4	2	7	34	
6	A	46	4	8	2	13	No playleader or teacher
4	A	26	7	8	8	58	
4	B	42	12	12	4	38	
5	C	44	3	15	4	16	
Total 28		260	44	59	31	29% avg.	
7	A	78	36	19	10	59	
4	B	42	3	2	34	88	
7	B	60	1	7	28	48	
8	B	81	18	8	24	53	playleader only
6	C	41	15	9	7	54*	
7	C	68	27	9	5	47*	
4	C	46	12	10	3	32*	
7	C	76	15	18	7	29*	
Total 50		492	127	82	8	50% avg.	
8	D	85	64	0	3	79	
6	D	71	45	2	6	69	
7	D	53	42	4	4	87	teacher (part play leader)
4	D	44	30	2	5	80	
7	D	75	33	4	27	80	
Total 32		328	214	12	45	79% avg.	

Summary

Positively Occupied

No Teacher or Playleader	29%
Playleader	50%
Teacher + (part play)	79%

* Playleader left at 3pm

Table 4:17 Chat Sessions (Afternoons)

Chat Parent	Chat Nurse	Chat Adult	Total Chats	No. of Children	% Children who Chatted
47	11	1	59	28	85
60	22	1	82	48	64
6	4	2	12	32	28
Total 113	37	4	153	108	---

In the afternoons the proportion of 'chat nurse' sessions was greater than in the mornings, and many of the nurses observed chatting were nurses in training. It was however, as could be expected, the parents who were mostly to tbe found 'chatting' to the children.

The occupations of the children in the mornings and afternoons will be presented graphically in tables 4:18, 4:19.

In the mornings the situation is clear. The playleaders interacted very little with the school age children. Visitors on wards A and D were numerous, but the occupation of children was carried out efficiently by all three teachers despite the complication of the geography of two of the wards. In the afternoon the picture is less clear. There were more visitors on B and C who chatted to children. One playleader was more successful than the other but her position was easier; the children were in one room where she could quite easily organise games unlike the children on the other ward who might be in several different places. The other playleader in any case did not appear to view the organisation of games as part of her role. The teacher on D often, but not always, had the help of the playleader and provided interesting and creative occupations for the children such as pottery, cooking, weaving, plaster modelling and clay. Thus the educational quality of the afternoon occupations varied as

Table 4:18 Occupation (Mornings)

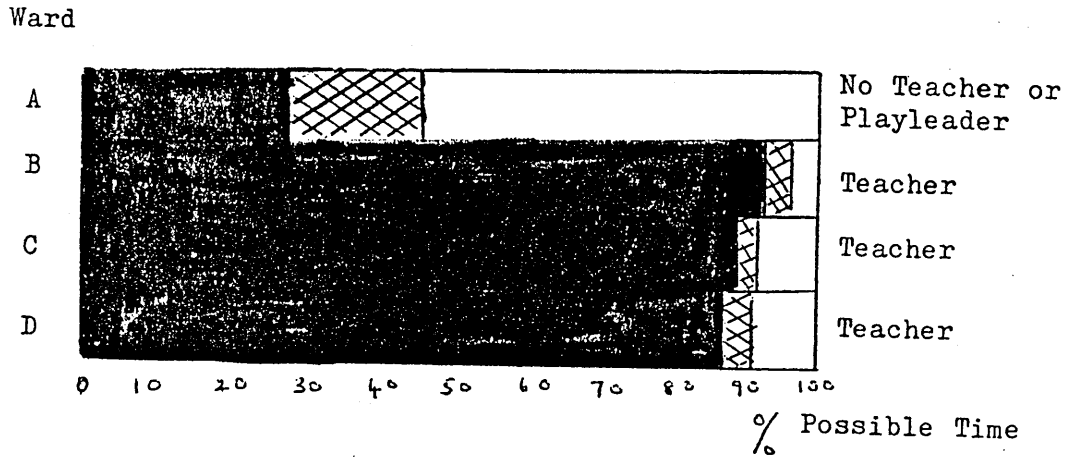
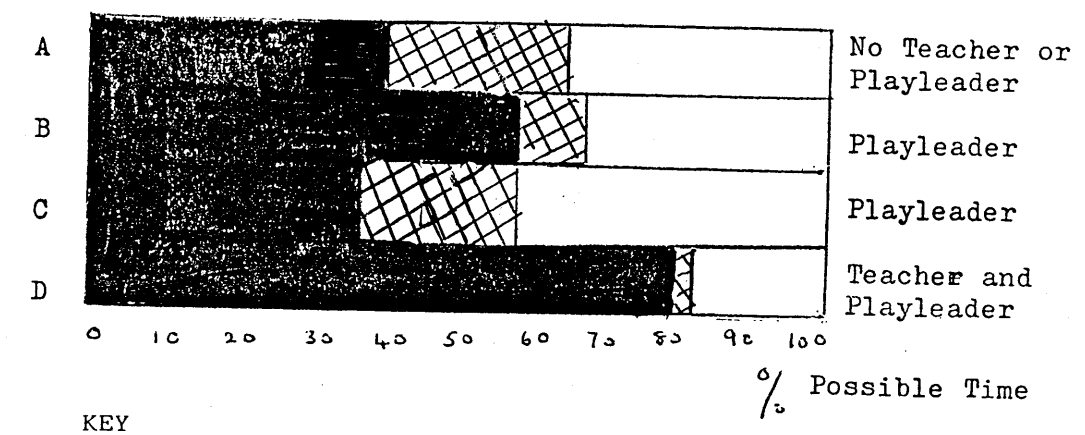


Table 4:19 Occupation (Afternoons)



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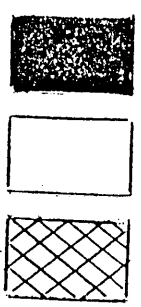

Positive Occupation Time

Waiting or restless activity time

Chat time

well as the time for which children were involved. On an average ward of 25 children, a number of whom are immobile, it is a large task to undertake craft work singlehanded with all ages of children for whom to cater. All that it is possible to say is that educationally craft seemed the right thing to be doing but it was less clear who should be undertaking the organisation of it.

In conclusion it can be said that on the whole the hypotheses were validated: all ages of children were taught by the teachers and, while the teachers varied in their approach, the curriculum was more or less normal if rather limited. Remedial teaching was undertaken after discussions with the children and on one of the wards there was teaching related to the hospital environment. Counselling was difficult to observe; it may or may not have occurred in chats with parents or children which could not be overheard. It was not possible to observe staff interactions very clearly but they seemed friendly. Children who had teachers were happily occupied; those who did not have teachers lay waiting on their beds or restlessly tried one occupation after another. The children responded to teachers as familiar figures of authority and to playleaders as fun providers or consolers as the need arose. Both roles were necessary.

It is now time to look at a different system, one that prevails in the U.S.A. mostly in University Hospitals and others which are privately funded, to see how a quite different approach affected the occupation of children in hospital.

Summary

The activities of children on four wards in four different hospitals during school hours were observed and analysed. When there was no teacher or playleader the activities were very limited despite the provision of a more than adequate supply of toys. Children were seen to be bored and

restless and constantly changing their occupations. Although teachers were employed for individual long-stay children, because they were not members of the ward team they could encounter difficulties.

When playleaders were in charge on their own or with nurses to help then sometimes older children were involved in imaginative and creative occupations, but more often school age children were left to their own devices. This was in contrast with the art and craft undertaken by the afternoon teacher with school age children on ward D.

In the mornings teachers, usually with an assistant, occupied the great majority of the children for nearly all of the time. An analysis of the activities shewed that the children were reading, working or playing work type games. Very little time was spent on other types of play or even on chatting. However on some wards the range of activities observed did seem to be rather limited. Most parents who were present sat quietly beside their children's beds but few made any attempt to occupy them. The morning ended at lunchtime and lunch was organised by the nurses. The teachers may or may not have used this time to chat to parents, talk to social workers, arrange home tuition or undertake social or therapeutic tasks. During teaching hours the teachers taught the children and during this time they were not observed counselling, or taking part in inter-disciplinary activities. However, the supportive role played by the nurses, despite the complications of medical treatments for the children, can only have been the result of negotiation by the teachers. This support was essential to the teachers.

The teachers were seen to carry out a normal school role and the children were seen to be occupied in educational activities and were not bored and restless as they were on the ward without a teacher. In this way education was seen as therapeutic.

Chapter 5

Ward Studies in the United States

In 1977 and 1979 the opportunity arose to visit the United States. The Observer's own profession meant that it was not difficult to make contact with hospital teachers and a N.A.W.C.H. committee member, one of the original campaigners in Battersea, made possible the contact with the Child Life (Play Programme) in the hospitals.[1] Altogether 25 hospitals were visited and discussions were held separately with child life workers and teachers. For the most part teachers were concerned with individual long-stay children. Children and their parents were interested in the child keeping up with his grade work and there was little confusion about the role of the teacher. Child life workers on the other hand were responsible for those aspects of care which were not directly medical. Many of them had Master's degrees which included a psychology element. In Wheelock College, Boston, one of the centres from which such workers came, there was a 4 year preparatory degree course half of which was teacher training, while the other half consisted of two years of hospital training. Other child life workers had qualifications in recreation or music, but most had made a study of the reactions of children to illness and the best ways to meet their needs.According to the hospital they might be called 'Playleaders', 'Recreation Therapists', 'Play Therapists' or, as the movement was trying to establish, be uniformly referred to as 'Child Life Workers'. (They will henceforward be referred to as C.L.W.'s).Teachers were employed by the local school district and their conditions were far from uniform. C.L.W.'s were employed by the hospital; they tended to work longer hours than the teachers and sometimes covered weekends. However their higher qualifications meant that their pay was more on a par with that of the teachers, in contrast to the British

Playleaders. Some teachers felt isolated and, while thy worked hard and dedicatedly, felt they were not appreciated. The C.L.W.'s unlike the teachers were accepted as hospital staff and had access to psychiatric support. In some hospitals there was tension because the C.L.W.'s ran programmes in the playrooms at the same time as the teacher was trying to extract children for tuition. In other hospitals there was more understanding, and tuition and play were conducted at different times.

No C.L.W. saw her task as just to conduct play and it is helpful to know something of the policy and guidelines laid down by the A.C.C.H. (The Association for Care of Children in Hospital, formed in 1965). In 1975 there were over 275 programmes being run for children and in the policy statement three goals are given: a) to minimise stress for the child and adolescent, b) to provide essential life experiences and c) to provide opportunities for the child to retain self-esteem and independence. A further aim was to encourage communication between parents and children and to give all warm support. It was suggested that the first aim was to be achieved both by providing play opportunities and by giving explanations of procedures to children who are already in hospital. They also provided information and pre-admission hospital orientation to those about to enter.[2] The brief for the C.L.W. can be seen to be wider than that of the British Playleader.

The American system had seemed advantageous and when there was an opportunity to make a third and longer visit to the United States a request was made to conduct the Observation studies on two wards, E and F, of a large teaching hospital where the standard of child care had long enjoyed a high reputation. Children of school age were divided: those aged 4-12 yrs were together and adolescents aged 12-18 yrs were on a separate ward. The younger age group had a teacher in the mornings and also had a tutor for some of the longer-stay children in the afternoons.

Longer-stay children were those in for more than one week. A C.L.W. or assistant conducted art and craft sessions every afternoon and in addition there were sessions in the evenings and at weekends.

Application had been made to the H.I.C. Committee* (The U.S. Ethical Committee) well in advance and by the time of arrival this permission had been gained; nevertheless research could not begin because another ethical committee had been set up by the nursing staff and it took 2 months to gain the neccessary permission. There was plenty of time therefore to meet with the staff and arrange the practical aspects of the research before undertaking the study. The situation in the hospital had changed from the earlier visits because of removal into new buildings. Not all the children had moved because of space problems and while ward E was still the adolescent ward it did house some younger children. Ward F which should have contained the younger children had some adolescents. This was probably a temporary state of affairs. In addition money to pay the teachers was short and permission to tutor individual children had to be gained from each child's education authority. It was by no means always given. Furthermore the teachers were given no financial support for books and equipment and had little of either. However they did have a small office and a large schoolroom and compared with the accommodation of the British wards this was spacious. The C.L.W.'s as well as the teachers provided a base for the Observer and this was very welcome in an atmosphere where the visitor had first to pass a guard to get to the wards at all. This is common in city hospitals in the United States but at first seems a little daunting. The C.L.W.'s had a suite of offices, a playroom for those of schoolage and a recreation room for both school age and adolescents. Despite the difficulties presented by the move the organisation of the children's activities still followed the same plan.

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* Human Investigation Committee

In addition to teachers and C.L.W.'s there were two types of volunteers at work under the direction of the latter. The first were students doing the job as part of their education or university course. They were of a high calibre. The second were volunteers who were carefully trained, being briefed before each session and then reporting after each session. Although they mostly worked with individual children, one special volunteer had been conducting an art and crafts session twice a week for many years. As well as these volunteers the Voluntary Services Organisation of the hospital provided two ward grannies who were paid a very small sum to come regularly to act in this role to long stay young children who had very little visiting. They were themselves grandmothers and played a marvellously understanding role with some very difficult children.

One of the difficulties that could occur was due to the racially mixed nature of American society, as the children might be black, white or hispanic, while those who cared for them were almost all white. Although there are many black children to be seen on British hospital wards, very few were present during the study. In the U.S.A. during the duration of the study all the nurses were white and several times during the sessions the ward cleaners, who were mostly black, took special care of a black child who needed attention. The children were mostly in single or double rooms and this must have been advantageous when parents were able to visit. When parents were not present, the single room seemed a lonely place and for little children who were non-ambulatory the constant presence of a ward granny was particularly comforting.

All in all the Teachers, C.L.W.'s and Volunteers exercised roles similar to those of their British counterparts but with significant differences in each case. Before summarising the observations made on the American wards a comparison of the children will be made to see whether their illnesses, length of stay in hospital, mobility and age range

Table 5:1 Reason for Hospitalisation

	Ward E	Ward F
Orthopaedic (Fractured Femur)	5 (2)	5 (1)
Ear/Nose/Throat (Tonsillectomy)	2 (2)	0 (0)
Gastro Intestinal (Appendicectomy)	7 (2)	6 (2)
Renal/Urinary	1	3
Investigations	0	0
Neuro - Muscular	4	1
Metabolic/Endocrine	0	4
Respiratory (Asthma)	2 (2)	5 (3)
Cardiac	1	3
Miscellaneous	3	5
Total	25	32

differed from those of their British counterparts (tables 5:1 - 5:4). These may be compared with tables 4:1 - 4:4.

Wards E and F did not appear to have any large group of children with one particular disease and there was little difference between the British and American scene. In the following tables the same child may appear more than once because each day's visit was treated as unique in compiling the tables. Table 5.2 shews the period of time for which children had been in hospital.

It can be seen that the teacher on ward F would have to take account of more long-stay children than the others.

Table 5:3 gives the mobility of the children.

Table 5:2 Number of Consecutive Days Already Spent in Hospital

Ward	1-3	4-6	7-10	11-20	21-100	Total for more than 1 week
E	18	10	5	4	5	14
F	15	13	5	9	6	20

Table 5:3 Mobility of Children

Ward	Mobile	Immobile	Total
E	14	28	42
F	32	16	48

Ward E had the next to highest proportion of immobile children (67%) and could be compared with D (with 73% immobile). Ward F was more akin to wards B and C.

The age range of the children is given in Table 5:4.

Table 5:4 Age Range of Children

Ward	4-7	8-12	13-16
E	1	17	24
F	26	17	5

A real difference was to be found here. Ward E had 24 teenagers, as well as those teenagers who were not included in the study because they were over 16 yrs, while ward F was similar to wards A and B in having a majority of younger children.

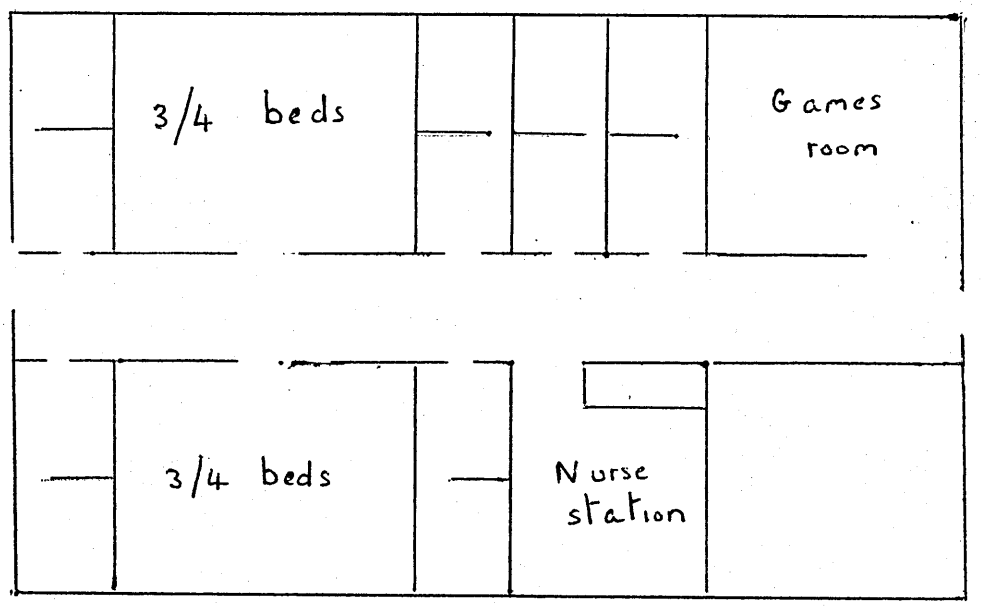
The tables have shewn that ward E unlike any other ward had a preponderance of teenagers and also a high proportion of immobile children. Ward F was comparable with A in having a large number of young children but also but had the highest number of long-stay patients.

In considering normality for the children these factors must be born in mind. Ward E like ward A had only tutors, who were seldom present during the study. The children would therefore be unlikely to be found doing school work but perhaps they would be reading or playing games. How successful would the teacher on F be in terms of the positive occupation of the children in the mornings? The two wards will now be considered separately.

Ward E

Ward E, the old ward for teenagers, held 14 beds with two rooms for three children and the rest single rooms. All were off one short corridor at the end of which there was a games room with a football game table, a cooker and a t.v., but little else. Each adolescent shared or had his own t.v. at a cost of 2.85 dollars a day, and while the Observer was there seemed able to have a choice of 4 programmes at any one time. This required but the pressing of a button, which occurred constantly. The nurses said that many sets remained on from 6am - 11.30pm and this was probably true. Virtually all the sets were on whenever the Observer was present. One or two programmes were generally popular and held the attention of the children: 'General Hospital' for obvious reasons and a soap opera about a family of adopted black children. In general the programmes seemed very uninteresting compared with the B.B.C. and, while television viewing was by far the chief occupation, the children constantly flipped the buttons to change stations. Besides a television, each child had a telephone by his bed and this was a facility much appreciated. It enabled

WARD E



Staff

1 tutor (pt)
1 Child Life Worker

Visiting

Open visiting
No children under 12

Children

14 beds

Age range observed

4-16 years

contact to be made both with home and school friends. It may have been expensive for parents but seemed very worthwhile (In another part of the U.S.A. the Observer had seen this idea extended to allow a teenager to

join his own school class). There was a games room but it was never seen to be in use unless a staff member or visitor was there.

During the course of the study several children were visited by an individual tutor from the hospital or from outside. Group programmes were arranged by the C.L.W. in addition to visits to individual children. On offer was one afternoon session which was often spent videotaping, and four evening sessions : Monday - Thursday where ward E teenagers could do arts and crafts on ward F, and Fridays when there was a family session on E. Weekends had two sessions on offer, again on F. Nurses said children could be moved there even if they were not mobile, but during the Observer's visit this did not occur. The programme did not seem very rigid and extra sessions seemed to take place on the ward itself from time to time. Much discussion was taking place about improving the facilities for these teenagers on E so that more events actually occurred on this ward instead of on F.

The method used for the Observation studies was the same as that used in Britain, but the study was much more difficult to carry out because of the presence of the children in individual and small rooms where it was not possible to enter the room without being conspicuous. The children often tried to chat to the Observer and it was not easy to avoid conversations. A noteworthy feature of this ward was the presence of a very long-stay young man aged 20 who, when he was feeling fairly well, took the part of a fond uncle. He was often to be seen chatting to the younger children especially those who were not feeling very well. The nursing staff on this ward were particularly welcoming and friendly and the free use of their office was most helpful for the writing of the Observer's notes. Tables 5:5, 5:6 shew occupations of children on ward E in the mornings and afternoons.

Table 5:5 Ward E Occupations of Children (Mornings)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	t.v.	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
7	5(0)	70	20	50	32	3	1	0	10	6	---
8	5(0)	70	25	45	28	0	0	0	9	0	---
10	10(0)	140	43	97	63	5	0	0	20	5	---
9	7(0)	98	31	67	30	0	2	0	28	0	---
9	8(0)	112	35	77	42	11	4	3	11	18	2 tutors
Total 43	35(0)	490	154	336	195	19	7	3	78	7% avg.	

Table 5:6 Ward E Occupations of Children (Afternoons)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	t.v.	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
8	7(0)	91	28	63	25	1	20	2	17	5	---
6	6(0)	72	15	57	38	0	19	0	16	0	---
8	8(0)	96	20	76	16	6	22	6	27	16	tutor c.l.w.
9	7(0)	104	21	83	29	1	23	9	21	12	tutor c.l.w.
7	7(0)	84	19	65	22	0	12	13	9	20	c.l.w.
Total											
38	35(0)	447	103	344	130	8	96	30	90	11% avg.	

On the first day television viewing was the chief occupation but it was not sustained and most children kept turning to look at the door. One or two children had the company of their parents and with the television remaining on chatted to them. There were very few books or games on the ward and as might be expected Amy, the solitary 5 yr old with an infection who would soon be transferred to a more appropriate ward, was the only one to be involved in a sustained game. She was hiding under a laundry basket pretending it was her house. She, even more than the others, tried hard to keep the Observer with her. In the evening there was a programme on offer but only two of the ward attended.

On the second day three of the four children who were using their telephones told the Observer how important they were to them. Patricia, a 10 yr old with bowel problems, knowing that she was a teacher, begged the Observer to try to get permission for her to attend school on the other ward and 13 yr old Hilary also with a bowel disease told the Observer that she frequently talked to her own school teacher on the telephone and then got a friend to bring the work to hospital. These two children, Patricia and Hilary, shared a t.v. and were to be seen watching operations and deaths in the programme. No teacher visited any child, but in the afternoon a student C.L.W. came to chat to Patricia for about an hour.

On the third visit 6 children made efforts to talk to the Observer. They did nothing but half-heartedly watch the t.v. However there was an exception: 15 yr old Mary Lou with chronic stomach pains was trying to teach herself sign language. The hospital tutor worked with a boy in the afternoon, and another boy enjoyed a football game with the 20 yr old in the games room. In the evening there was a videotaping session in which three, including the 20 yr old, joined. This roused the interest of the whole ward and was still being discussed on the next day's visit.

The fourth morning was noticeable for the interaction of the 20 yr old who chatted and encouraged Mary Lou who commented that his presence on the ward had made hospital tolerable for her. Two girls walked up and down the corridor most of the morning while two bedfast children watched, or appeard to watch, t.v. without ceasing. Two children had school books by their beds but ignored them. The afternoon was much more lively with three of the children taking part in pizza making organised by the C.L.W. from which adults were barred. At the end of the afternoon a tutor arrived for the 12 yr old, Janey, who had been in hospital for many weeks with a bowel disease. On day 5 two tutors (one the hospital tutor) visited children for about 40 mins. In the afternoon the student C.L.W. asked all children to play a board game in the games room, but despite visiting each child twice, only two were persuaded to join in. While this activity was not particularly successful the individual visit to a boy by the C.L.W. on the previous evening got high praise from a mother.

It is clear from these tables and the Observer's description that in the terms of this study there was little positive occupation of children during school hours. The highest proportion of the time was spent watching t.v., but this was a distracted occupation because the children were constantly switching programmes and also were viewing the doorway to see who would pass by.

A further point of interest is to see in table 5:7 which adults were involved when work or games did take place. The table may be compared with 4:7. On this ward during the study hours no nursing time was spent occupying children. There were no student nurses and the medical condition of some of the children kept all the nurses busy. As compared with ward A, the children were much older and it is therefore perhaps not surprising that parents who visited their children seldom played games with them unlike those on A.

Table 5:7 Ward E Adult Interactors with Child's Work or Games (sustained)

Day	Possible 10 Mins. Sessions	Read Work Workgames	Adult Interactor			Total Continuous	Adult Interactor		
			Tutor	Parent	Nurse		C.L.W.	Parent	Nurse
1	113	4	0	2	0	2	0	0	0
2	102	0	0	0	0	0	0	0	0
3	173	11	6	0	0	6	6	0	0
4	150	1	1	0	0	9	8	0	0
5	142	11	8	0	0	16	8	3	0
Total									
	680	27	15	2	0	33	22	3	0

On three days tutors visited, and the tutor on day 4 arrived only as the Observer was leaving. The work sessions in the absence of the tutor consisted of reading, colouring printed pictures or letter writing (total 12 sessions). The small rooms with their own t.v.'s and telephones might well have been the choice of parents for their teenage children but to the Observer they seemed impersonal and isolating of the children and possibly were the reason why, as on no other ward, the children made determined efforts to talk to the Observer. The age mix was clearly unfortunate and the younger children said they wished to attend school. However the situation might change and the ward revert to teenagers only. Books and games were noticeably absent and this may have been a result of the move. However mention must be made of the very warm and friendly atmosphere which must have been very supportive to many of these seriously ill children.

Ward F

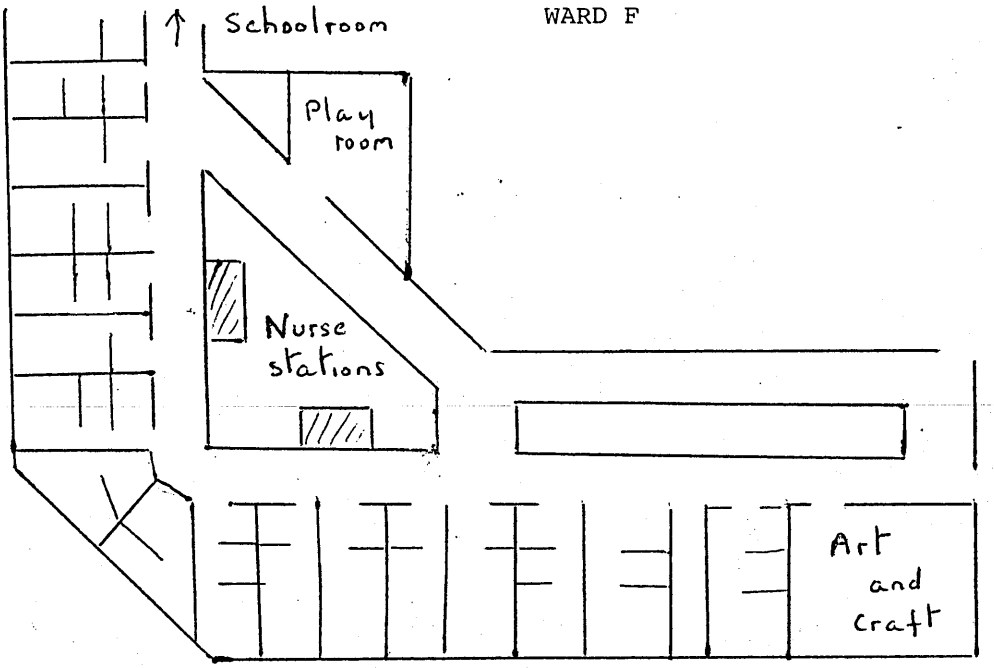
Ward F was at some distance from ward E and at the beginning of the study was divided into two parts for administrative purposes. Each part held thirteen beds in three single and five double rooms. By the end of the study one head nurse was in charge of both areas. From the teacher and C.L.W.'s point of view they were one unit, there being no physical barriers in between. The facilities included a large arts and craft room with a football game table, a smallish playroom with quite a number of toys, and a large school room. Each child had a t.v. above his bed and again there was a lot of viewing. There were no bedside telephones. C.L.W.'s spent a good deal of time with individual children and in addition they had an advertised child life programme:

Child Life Program

Weekdays	Afternoons			
	Monday	2-4pm	Crafts	Volunteer
	Tuesday	3-5pm	Play	C.L.W.
	Wednesday	3-5pm	Play	C.L.W.
	Thursday	2-4pm	Crafts	Volunteer
	Friday	3-5pm	Play	C.L.W.
	Evenings			
	Programmes most evenings to be arranged			
	Thursday		Puppet Show	
	Friday		Arts and Crafts	
Weekends	Saturday	11-12.30	Play	C.L.W.
	Sunday	11-12.30	Play	C.L.W.

Observation studies were carried out as before and when children were in the school room the Observer could sit unnoticed in the glass fronted teacher's office. On the ward it was very different, as it was not always possible to view children from the doorway. Also at times it was very difficult to find children as there were many places they might be if they were mobile. The results of the studies are shewn in tables 5:8 and 5:9.

On this ward there was a nurse's staff meeting every morning which could last from 8.45 to 9.45 or could be over by 9 o'clock. Neither the teacher nor the Child Life Worker could start work until the head nurse had checked over the list of children with one or other of them following this meeting. The process took about 2 mins. Although the ward studies started earlier subsequently, on the first day permission was not given to start until after this briefing. That day the teacher managed to start



Staff

1 teacher
1 Child Life Worker and Volunteers
2 ward grannies

Visiting

Open visiting
No children under 12

Children

24 beds

Age range observed

4 - 15 years

at her usual commencement time of 10.15am with a few children, while the C.L.W. failed completely in her attempt to gather the younger children together in the playroom. Two children from a special research ward (one of them quadraplegic) should have joined the school but did not arrive until dinner time. For some reason they had thought the teacher was absent.

The teacher had a warm personality and immediately created a friendly atmosphere and 5 of the children between the ages of 5 and 10 spent some time in school. The teacher started a discussion of their news and then the children drew pictures before having a game of pelmanism. Glenn

Table 5:8 Ward F Occupations of Children (Mornings)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	t.v.	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
8	7(1)	77	24	53	5	24	8	8	7	60	teacher c.l.w.*
10	8(3)	96	27	69	3	22	16	12	18	49	teacher c.l.w.*
12	11(0)	140	32	108	26	39	9	6	14	42	teacher c.l.w.*
11	11(1)	149	24	125	36	40	6	4	20	35	teacher granny
11	11(2)	146	45	101	19	40	16	15	6	54	teacher granny
Total											
52	48(7)	596	152	444	89	165	55	45	65	47% avg.	

* Child Life Worker or Child Life Volunteer

Table 5:9 Ward F Occupations of Children (Afternoons)

Total No. Children Schoolage	No. in Study ( ) aged 4	Total 10 Mins. Sessions	Bath/Eat Med/Leave Sleep Distressed	Possible 10 Mins. Sessions	t.v.	Read Work Workgames	Total Games	Continuous Games	chat	%Time Positive Occupations	Staff
9	8(1)	90	10	80	7	8	28	26	11	42	tutor c.l.w.(3)
6	6(3)	72	18	54	8	7	14	9	11	30	tutor
12	10(0)	127	43	84	33	18	20	20	4	45	tutor(2) c.l.w.
10	8(1)	104	20	84	24	13	10	4	14	20	tutor(1) c.l.w.(2)
5	5(2)	60	16	44	14	5	0	0	17	11	granny(2) granny(2)
Total											
42	37(7)	453	107	346	86	51	72	59	57	32% avg.	

* Child Life Worker or Child Life Volunteer

(14) was too old for school which was a pity as he had been in hospital for 3 weeks and, like those on E, he was not very interested in the television. In the afternoon two of the longer stay children (one with an injury to the alimentary tract and the other a fractured femur) had individual tuition sessions of about 40 mins each with the teacher. Jamie, who had the fractured femur, was 9 years old and when on his own in his room became quite distressed. The C.L.W. spent quite a substantial part of the afternoon with him on his own. She also had a successful time with 5 children out on the terrace where there was a sandpit. Two other volunteers played games with individual children. A mother stopped to tell the Observer that in the New York hospital, where her child had previously been sent, there were plenty of toys but no one played with them because there was no adult to organise anything.

On day 2 the nurse meeting was over by 9.30am but still nothing got going until 10.20am, even though the C.L.W. had been standing around for over an hour. There were so many places where a child might be found and a merry charade took place while the C.L.W. hunted round the rooms for her volunteer who all the time was talking to the teacher in the school room. Restless small children moved in and out of the playroom and school room, for while the volunteer and the teacher were busy fetching more children those that had arrived earlier left. The problem was that the children declined to stay in the rooms without the adults, but unless those same adults fetched the children no one else did so. The nurses appeared to play little part in the organisation.

School started with children giving their news (of themselves or family) followed by word unscrambling games. A favourite game was coffee pot, a form of 20 questions; then the teacher read a ghost story which was greatly enjoyed by the children. After this she shewed the children a model of a paper bag puppet (spendid strong brown paper bags are used in

the food stores to wrap all the food and so are easily available) and the children proceeded to make their own puppets. Rolly, the 10 yr old who had been in the playroom not the schoolroom, came in and said with regret that he wished he had come earlier. He had been having a loud verbal battle with Rick aged 5 and told the teacher that he hated him because he was so annoying and would give him a heart attack! Jamie the 9 yr old with a fractured femur was very worried about his leg and discussed it with the teacher. The delight of the afternoon was the regular biweekly visit of a representative of MacDonalds foods who gave each child a small box of toys and puzzles. This came as a nice surprise. The teacher attempted to teach Dolly (7) and Rolly (10) individually, but Rolly with a cardiac condition had been hospitalised many times in the past and knew how to manipulate the system and infuriate all! He screamed and screamed over a blood test and other children flocked to his room; then he went to the nursing station in the absence of all of the nurses and attempted to operate the phone while issuing orders to all who passed by; he pretended to the teacher, who was unsure whether to believe him, that the doctor had told him to rest; he vanished from view and his mother was to be seen hunting for him everywhere. Once again it had been hard to discover the whereabouts of children if they were not in their rooms.

On the third morning there were 8 children who were possible candidates for school. Reports ended and at 10.30am the teacher managed to start with 5 children. Parents wanted their children in school, but neither they nor the nurses appreciated that the teacher needed help. A volunteer arrived at 11 o'clock to help the teacher, but turned out to have major problems of her own which now occupied the teacher's time and sympathy. As before the children shared news and then enjoyed untangling next week's menu off the board: APE SOUP, TEAM FOAL, CHEAP BLAME. Two children were rather resentfully doing their own school work in their

rooms with their mothers. Jamie was one of these and kept trying to talk to his mother about the plaster he would have on his leg. In school the teacher told a story and then shewed her own film strip about a hippopotamus, which the children enjoyed. Meanwhile to the annoyance of the teacher a doctor walked in and did a blood test - screams ensued and the happy atmosphere was destroyed. Children then traced pictures of animals. At lunch time Jamie had a lesson with the teacher while the rest joined in with the big event which was a taco* party (the teacher did not know about this party).

All possible children and their parents went to the large art and crafts room; members of ward E were invited and two came. Children made up or ordered their own tacos, and there were cookies and fruit sent up by the kitchens. The C.L.W.'s made a party atmosphere for all in which 7 children joined although the teenage boy left almost immediately. After the party one of the two C.L.W.'s played and sang to two of the younger children, which delighted them. The afternoon was restful; the tutor found two pupils and also comforted Jamie, who also has had some attention from a ward granny.

On the next visit there were 11 children in the morning study; one was Rita with a bone disease but she was 13 and therefore not within the province of the teacher. She looked very bored watching t.v. all the morning and her mother commented that there was nothing else that she could do anyway. She shared a room with Sena, a sad little coloured girl of 5 with asthma, who played a game with her playpeople while her mother was there, but at 10 o'clock her mother reluctantly went and she watched t.v. on her own.

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* A 'taco' is a Mexican version of a crisp savoury stuffed pancake.

Jonathan was 4 and had major burns but a ward granny took him to school and looked after him all the afternoon. Four children spent time in school with the teacher, and the school time followed a pattern. On arrival puzzles, blocks and plasticine awaited the children. There were word puzzles written on the blackboard, and when they had done these the children discussed their news. There was then a special interest subject, like 'Thanksgiving' or the bones of a skeleton, which led to a discussion. Next there were remembering games like objects on a tray or guessing games like coffee pot, which all the children enjoyed. Next came drawing pictures or making collages related to the special subject, and if there was time there would then be another communal game. The more academic work was left to the single hour session with the teacher. In the afternoon two ward grannies were busy with the 4 yr olds and one child was tutored. The rest of the children chatted or watched the television until two C.L.W.'s arrived for a session starting at 3 o'clock, and 6 out of 7 children then available happily drew pictures of life in hospital. The seventh was a 5 yr old with asthma who was very bored watching t.v. on her own all of the afternoon.

Day 5 and Merv, a 4 yr old, had the company of his nurse or ward granny nearly all day. The nurse played with him in the playroom and the granny read his favourite book on helicopters. Johnathan (4) with burns also had the company of a nurse or ward granny. The programme followed the same pattern, but this time the children made Indian headdresses. It ended early because a little girl with burns was in pain and the teacher had to take her to her room. This led to the other children drifting off. It was the start of a holiday period and all but three children went home at lunch time. These three did nothing or watched t.v. until, as the Observer was leaving, the C.L.W. student arrived to play games and draw pictures.

On this ward there was a real problem in trying to locate the presence of the children once they were mobile. This difficulty has been seen to be shared by both teacher and C.L.W. The number of staff, such as C.L.W.'s, volunteers and ward grannies, has been seen to be impressive. What was lacking was the organisation to support the activities on offer and it was this support which needed to be the subject of negotiation. However despite the difficulties and the lack of equipment, those children who attended school (and these included children who spoke little English and one who was quadraplegic), enjoyed an interesting and imaginative programme which might not have seemed very different from a class in a British primary school. In addition, longstay children had the possibility of individual tuition in the afternoons.

The morning occupations on E and F are summarised in table 5:10 and may be compared with those on the British wards table 4:14. The two wards provided a contrast in the mornings with 7% occupancy on E and 47% occupancy on F. However the teenagers and the others not occupied by the teacher on F mostly behaved like the children on E. They halfheartedly watched the t.v., constantly switching the channels. It is quite possible that if children on the British wards had had the same easy access to the t.v. they would have behaved in the same way. However on the American wards there did seem very little alternative provision which could be generally available to the children and it may be that the parents thought that the television would keep their children happy. The C.L.W.'s had interesting toys for the children but, as in all hospitals, it was impossible to leave toys out without supervision because the toys would either have got broken or have vanished. After t.v. viewing the next most popular occupation was chatting. The chat sessions can be viewed in table 5:11 in which a column is included for telephone conversations. These may be compared with the results in table 4:15.

Table 5:10 Morning Occupations of Children Wards E and F

No. of Children	Possible Sessions	Read/Work Workgames	Chat	t.v.	Continuous Games	% Time Positive Occupations	Staff
5	50	3	10	32	0	6	
5	55	0	9	28	0	0	
10	97	5	20	63	0	5	E (no teacher)
7	67	0	28	30	0	0	
8	77	11	11	42	3	18*	
Total							
35	346	19	78	195	3	7% avg.	
7	53	24	7	5	8	60	
8	69	22	18	3	12	50	
11	108	39	14	26	6	42	F (teacher) (c.l.w.) (granny)
11	125	40	20	36	4	35	
11	101	40	6	19	15	54	
Total							
46	444	165	65	89	45	47% avg.	

* 2 tutors present

Summary

Positively Occupied

No Teacher 7%
Teacher 47%

Both of the wards E and F were found to be comparable with A in the % of children recorded as chatting. Most chats were with parents. On E a number of chat sessions were on the telephone and many of the chat 'adult' sessions were with the 20yr old patient. Although more chat sessions with nurses occurred on F than E, the total number was small.

Table 5:11 Chat Sessions-Mornings

Ward	Chat Parent	Chat Nurse	Chat Adult	Chat Phone	Total Chats	No. of Children	% Children who chatted
E	46	8	16	8	78	42	57
F	40	15	10	0	65	48	61
Total	86	23	26	8	143	90	

The afternoon sessions are reviewed in table 5:12.

In the afternoons the ward F children were more positively occupied than those on ward E. The children were younger and there was more provision for them in terms of C.L.W.'s and grannies. For ward F children a programme was scheduled for each afternoon* but owing to illness the schedule was not always followed in practice. Moreover the timing of the sessions did not coincide with the hours of the study. For this reason no direct comparison with what happened on the British wards was possible.

In terms of positive occupations of children during school hours, it can be said that the rate was very low on ward E. On F the rate was also low; this was not surprising because the teacher did not start until 10:15 which meant that the morning school period was very short.

The afternoon chat sessions are reviewed in table 5:13. The majority of Chat sessions were with parents but there did seem to be relatively few of these on F. The Chat adult sessions were mostly with C.L.W's and ward grannies. There were few chat nurse sessions. The morning and afternoon occupations of the children will be presented graphically in tables 5:14, 5:15.

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* See above p. 103

Table 5:12 Afternoon Occupation of Children Ward E and F

No. of Children	Possible Sessions	Read/Work Workgames	Chat	t.v.	Continuous Games	% Time Positive Occupations	Staff
7	63	1	17	25	2	5	
6	57	0	16	38	0	0	
8	76	6	27	16	6	16	E (c.l.w.)
7	83	1	21	29	9	12	(tutor)
7	65	0	9	22	13	20	
Total							
35	344	8	90	130	30	11% avg.	
8	80	8	11	7	26	42	
6	54	7	11	8	9	30	
10	84	18	4	33	20	45	F (c.l.w.)
8	84	13	14	24	4	20	(tutor) (granny)
5	44	5	17	14	0	11	
Total							
37	346	51	57	86	59	32% avg.	

Summary

Positively Occupied	No Teacher	E 11%
		F 32%

Tables 5:14 and 5:15 summarise the situation on E and F during school hours. In the mornings most of the positive occupation time of 6% on E was due to the presence of a part time tutor, and on F the positive occupation time of 48% was due to the teacher's presence in the schoolroom. In the afternoons C.L.W.'s and a tutor account for positive occupation times of 11% on E, and tutors, C.L.W.'s and ward grannies provided the limited amount of occupations on F (32%).

Table 5:13 Chat Sessions(Afternoons)

Ward	Chat Parent	Chat Nurse	Chat Adult	Chat Phone	Total Chats	No. of Children	% Children Who Chatted
E	76	1	13	0	90	35	69%
F	26	7	24	0	57	37	59%
Total	102	8	37	0	147	72	

Table 5:14 Occupation (Mornings)

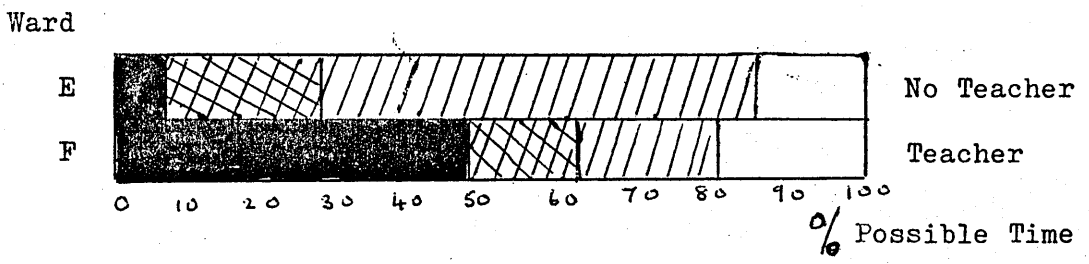
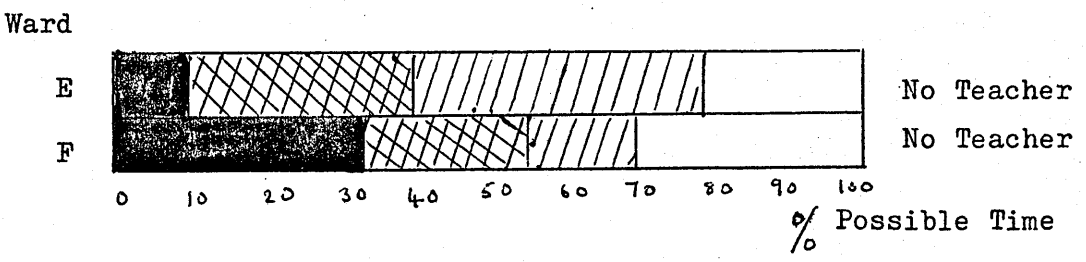
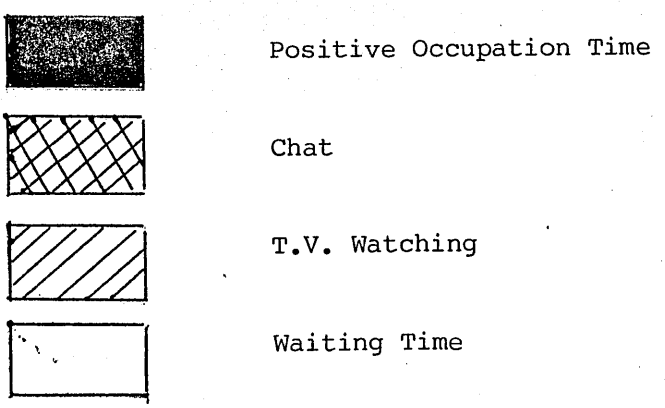


Table 5:15 Occupation (Afternoons)



Key



In this hospital much attention was given to the provision of good care of teenage children. Evening programmes, t.v., telephones, counselling sessions, special events and tutoring of long-stay patients were all helpful. Sadly the education department played only a small part in the life of the ward and this was particularly hard on the younger children on E as well as the teenagers on F. There was no concept of normality of education for all, and thus little relief of stress through occupations of a creative and stimulating nature at least during school hours.

On ward F the position for the schoolage children was quite different. The children who joined together in a group, whether for school or to join in with the taco party or guitar singing or art sessions, seemed able to forget their illnesses and get involved like other children in the interests and occupations of childhood. The aliveness of these children was in contrast with the boredom of so many of the rest.

It would be easy to conclude that this boredom from which the children suffered is a fact of life - children get bored at home. But in this hospital no expense was spared to try to act in the interests of children. There was no lack of personnel and the contribution that education made to the welfare of the children was heartening when it could take place. Perhaps it was rather that the institution of the hospital had not understood the difficulty of the task, and with insufficent communication the teacher was isolated. Television was thought to provide the necessary relief but the study shewed that this was not the case. It was a companion of the dumbest kind.

The American studies have shewn how bored the children appeared when there was no teacher, but it may be argued that it is not a proper task to install teachers just to help children overcome boredom, even if boredom can be seen to be quite unhelpful to the progression towards good

health. The question must now be asked as to why this should be seen as an educational task requiring a teacher.

Summary

A similar study was undertaken on two wards of a hospital in the U.S.A. where highly qualified recreational specialists known as Child Life Workers were employed by the hospital to look after the needs of the children which were not medical. On the predominantly teenage ward, where there was a visiting tutor for a few of the children, television sets were viewed from early in the morning until late in the evening. Each child could see a set from his bed. Very few children read books or played games although bedside telephones were used by one or two with obvious enjoyment. Few group activities happened during school hours but they were enjoyed when they occurred. The children watching television appeared very bored and they were to be seen constantly switching programmes. On the second ward which was mostly for children aged 4 - 12 television viewing was similarly a continual activity throughout the day but one which seemed very boring for the children. In the mornings there was a teacher for all children who could go to the schoolroom, but due to lack of assistance and lack of equipment the school activities which were much appreciated by the children were enjoyed by only a few. Child Life Workers also conducted group activities in the afternoons and the enjoyment of those who attended the events was in marked contrast with the boredom and isolation of those children who were alone in their rooms.

The study underlined the difference made by the presence of the teacher and the value of negotiation in achieving any success. The involvement of children in group activities in a hospital is seen to be a complex task which requires highly trained staff, suitable equipment and the support of all the ward staff.

References

1. Wiles, P., 'Hospitalised Children in the U.S.A.', Journal of Special Education: Forward Trends, Vol. 6, No 4, 4 Jan. 1980, p. 23.

2. A.C.C.H., 'Guidelines for the Development of Child Life Programs', p. 35.

Chapter 6

The Role Teachers Fulfil - Is it Educational?

The ward studies shewed that when teachers were present on hospital wards, the children were positively occupied. When teachers were not present the children seemed bored and sometimes lonely. The teacher questionnaire found that the most common reason given for finding hospital teaching to be rewarding was because in providing normality for the children teachers could see how therapeutic was the service. Self evidently the positive occupation of the children was more conducive to their happiness and recovery than was absorption in their illness. It might be suggested that the positive occupation of children could be carried out by others and in particular that parents, volunteers or playleaders would be thought excellent substitutes. However the ward studies shewed that most parents failed to occupy their own children and the few volunteers observed worked successfully with a limited number of children when under the direction of the teacher or the child life service. On wards B and C the playleaders were on their own with the children in the afternoons. The playleader on C was the only one to attempt to occupy all the children and she had some success but much less than the teacher. She had after all no assistant and no volunteers. On D the playleader was often to be found assisting the teacher and this cooperation and interaction seemed to work well.

But even if it is clear that teachers were the most successful in the occupation of children of school age, the question still remains to be asked whether in so doing they were fulfilling an educational role. There is no straightforward answer to that question, but an approach will be made along two different lines. In the first place there are general issues to be raised about what constitutes 'an educational role' and use

will be made of the writings of Jean Piaget who has been a very influential figure in British education. An attempt will be made to see how his guidelines can be applied in the hospital situation, and what light these may shed on the understanding of what constitutes education in that setting. Secondly attention will be given to notions of testing and assessment in relation to education generally, and how far such notions can be applied to the evaluation of the activities of children in hospital. Only after surveying this evidence will an attempt be made to answer the question as to whether the teacher fulfils an educational role. At this stage the findings about the activities of a number of the longer stay and recurrent children will be considered in more detail and the nature of the occupation of the short-stay children will be reviewed.

Piaget's influence on the child-centred learning of British primary schools has been enormous.[1] He predicted phases and stages through which all children must pass and a knowledge of that developmental order can be helpful to the teacher in seeing how the child is viewing the strange world of the hospital. A table adopted by Maier from a paper of Piaget's gives an outline of his developmental view.[2] (table 6:1)

Teachers need to be concerned with the three phases in which children of school age are to be found: the intuitive thought phase, the concrete operational phase and the formal operations phase. An understanding of how the child is thinking is vital to the task of teaching anything at all. In Bruner's words

> The task of teaching a subject to a child at any particular age is one of representing the structure of that subject in terms of the child's way of viewing things. The task can be thought of as one of translation.[3]

The dominating concern of a child in hospital is his illness and it is important to recognise the child's distinctive way of viewing it. He overhears much that goes on and confusion arises only too easily. Eudora

Table 6:1 Maier's Table

Modality of Intelligence	Phases	Stages	Approximate Chronological Age
I. Sensorimotor Intelligence	Sensorimotor Phase	1. Use of reflexes	0 to 1 month
		2. First habits and "primary" circular reactions	
		3. Coordination of vision and prehension, "secondary" circular reactions	4½ to 9 months
		4. Coordination of secondary schemata and their application to new situations	9 to 12 months
		5. Differentiation of action schemata through "tertiary" circular reactions, discovery of new means	12 to 18 months
		6. First internalization of schemata and solution of some problems by deduction	18 to 24 months
II. Representative Intelligence by Means of Concrete Operations	Preconceptual Phase	1. Appearance of symbolic function and the beginning of internalized actions accompanied by representation	2 to 4 years
	Intuitive Thought Phase	2. Representational organizations based on either static configurations or on assimilation to one's own action	4 to 5½ years
		3. Articulated representational regulations	5½ to 7 years
	Concrete Operational Phase	1. Simple operations (classifications, seriations, term-by-term correspondences, etc.)	7 to 9 years
		2. Whole systems (Euclidian coordinates, projective concepts, simultaneity)	9 to 11 years
III. Representative Intelligence by Means of Formal Operations	Formal Operational Phase	1. Hypothetico-deductive logic and combinatorial operations	11 to 14 years
		2. Structure of "lattice" and the group of 4 transformations	14 years - on

Welty, a remarkable recorder of children and adult dialogue, described two children when they went for a walk.

> 'That's to Marmion' said Orrin (14) to Laura (9) kindly. He waved at an old track that did not cross the river but followed it, two purple ruts in the strip of wood shadow.
> 'Marmion's my dolly,' she said.
> 'It's not, it's where I was born,' said Orrin.
> There was no use in Laura and Orrin talking any more about what anything was.[4]

The signals by which they interpret what the doctors and nurses say are not necessarily verbal. A nine year old talks to her aunt.

> 'Ho hum', said India....'Aunt Tempe, I bet you don't know something you wish you did'
> 'What child?' asked Aunt Tempe sharply.
> 'I bet you didn't know Aunt Robbie ran away from Uncle George and never is coming back'...
> 'Oh, the mortification! Who told you, baby? And when?'
> 'I'm nine' said India. 'Nobody told me, but I knew way back this morning.'[5]

Some limited research has been carried out in the U.S.A. to find how children viewed their illness.

Two recent research studies may be of help to the teacher in this respect. Arline Brewster[6] interviewed 50 chronically ill children aged between 5yrs and 12yrs 11mths in their own rooms in hospital. The illnesses were diverse but 15 suffered from diabetes and asthma and 11 from orthopaedic conditions. Roger Bibace and Mary Walsh[7] interviewed 24 children: eight aged 4yrs, eight aged 7yrs and eight aged 11yrs in their own schools. Both studies were concerned with the child's concept of his illness.

In the first study there was found to be a three stage sequence of conceptual development in understanding the cause of illness. 1. Children aged 5-7 yrs believed that illness was caused by human action e.g. a sandwich that was spoilt. This was often the result of wrongdoing. 2. Children aged 7-9 yrs believed that illness was caused by germs e.g. someone coughed in your face. 3. Children of 9yrs and over believed that illness was caused by physical weakness or susceptibility. A parallel three stage understanding of the intent of medical procedures followed.

1. Procedures were a punishment. 2. The empathy of staff depended on the patient expressing pain. 3. The child could infer intention and empathy from the medical staff. Bibace and Walsh saw contagion, contamination and physiological explanations as most prevalent at 4, 7 and 11yrs. Both research studies saw in these explanations an understanding that was in line with the Piagetian stages.

In discussion of the results Brewster expressed the opinion that it was essential to gather information from the children before explanations were offered. Children should not be given explanations beyond their present level of cognitive functioning. It was her view that the well informed patient was not necessarily the coping patient. Some teachers in this study regarded listening to and informing children about their illness as diversionary;[8] they shared the opinion of Mabel Schulen that it was normal school tasks that needed to be accomplished. The difficulty in that view is that thoughts about illness are never far from the children's minds; moreover when children do express their thoughts in speech, writing or art, the teacher, whether she wishes it or not, has to decide on some approach to follow. Even if the time is spent entirely on English Grammar exercises, the very normality of the teacher's presence may lead the child to open a discussion. It may be that it is more the role of the doctor, nurse or parent to talk to the child about his illness but the necessary time and skills are not always available for them to do so. Doctors do not generally take time in their rapid visits to listen to what the child has to say, though in the U.S.A. Dr. Granger has spent a great deal of time endeavouring to promote the training of doctors in this area.[9] Similarly, although the new course for paediatric nurses[10] lays much more emphasis on child development, their time with individual children is in practice limited;[11] some parents do have the knowledge to help their children express their feelings about illness but

for the most part they are concerned with the complications and alterations of their daily lives which this visit to the hospital has brought them. In the U.S.A. C.L.W.'s have developed fine skills in this respect.[12] They believe in listening to the child, knowing that he needs to express his concerns as he views them.[13] It may appear time consuming but for all concerned it is never a waste of time to learn why the child is distressed in his own view. Often the reason is a surprise. Bibace and Walsh[14] tell the story of a 7yr old boy who visited the doctor's office and explained guiltily that he had got a rash because he had refused to eat his mother's soup, had run into the garden and been infected by poison ivy. His 9yr old sister told him he had a rash because he'd swallowed germs off his friend's lollipop that he'd been licking. Actually it was a heat rash.

Children not only misunderstand their illnesses by adult standards but are confused by much that goes on in hospital. Piagetian stages imply that fixed times like meal times are only grasped by children of 7/8 or more, and so a child who is told by his mother that she will be back after supper feels that she has simply gone away. David Elrond suggests that the reason children dawdle at bedtime is because they think bedtime comes when you actually get there.[15] An understanding of the child's fuss at his mother's 'only going for half an hour' is more acceptable when understood in these terms.

Piagetian categories can also be of help with another problem that frequently arises in a hospital, the answering of questions asked by the children even if that question concerns death. A child up to the age of 5 has to be answered in terms of purpose[16] or in terms of storytelling. Purposivenessis a common feature of children's storybooks: 'The giraffe has a long neck to reach fruit that grows high in the trees.' From 5-7yrs, it is better to explore the meaning of the question before an-

swering. After 7yrs, as concepts of space and time develop, more adult type answers are appropriate.

The concern so far has been with the child's attitude to his illness and the need for the teacher to understand this as a necessary preliminary to her more narrowly educational task. Moreover stress has been laid on the value of Piaget's work as a guide to such understanding. But Piaget can also be an invaluable guide to the most appropriate ways of carrying out the directly educational task itself in a hospital environment. A move is now made to this aspect of the consideration and begins with some words of two very experienced observers and teachers, Donna Hetzel and John Coe, who joined David Elrond in a study of 'Piaget and British Primary Education'.

> One unique insight about children that informs all of the child-centered education practised in England is the belief that children learn best by experiencing the world directly and then reconstructing, reconstituting or representing it in ways that are appropriate to their individual talents and abilities. By recasting it in a mould of his own thinking, the child integrates it into his own personal conceptual system and makes it his own.[17]

The hospital embodies an experience of the most powerful, important and interesting kind. It is one that is life-lasting and one with which both the child and his family are totally involved. A child has plenty of time to observe his new world, and the teacher can give him the opportunity to explore and represent it.[18] Fascinating scientific equipment is round every corner.[19] The situation is ideally suited for the teacher to be a catalyst 'releasing the powers of the children' rather than instructing them. The child is interested in the world of the hospital. The teacher has only to provide the tools and start the exploration.[20] In 'Piaget and British Primary Education' the authors spell out what they mean by the 'truly educated person' at some length.

> The Piagetian distinction between acquiring knowledge and acquiring representations does more than highlight some fallacious educational assumptions. Perhaps its greatest

> value is to point to a central task of education that the traditional identification of representation with knowledge has caused us to overlook. This task involves helping children to construct meanings, the relations between knowledge and representations. As the foregoing arguments demonstrate, the relations between knowledge and representations are not given but have to be actively constructed by the child. In contrast to knowledge, which is acquired by rational processes, and representations, which are acquired by imitations and associations, meanings are acquired by discovery and by invention.
>
> From a Piagetian standpoint, therefore, the task of education is to facilitate the child's acquisition of knowledge, of representations, and of meanings. To accomplish this, education has to provide the child with opportunities: to continually interact with the real world; to interact with sympathetic adults who are skilled models of various systems or representation; and to relate their conceptualizations of experience to their developing representational skills (to acquire meanings). From the standpoint of Piagetian theory the most neglected task is the last one, providing children with the opportunity to represent their experience in a variety of different ways. In the end, the truly educated person is the one who can articulate what it is he knows and has learned.
>
> Clearly, the child-centered educational program practised in some British primary schools closely parallels the educational program suggested by Piagetian theory.

This view of the teacher as a catalyst or one who gives the children the opportunity to represent experiences does not imply an easy task. Children of all ages and abilities enter hospital and the guidelines of Piaget in the areas of Reading, Writing, Art, Maths and Science are helpful. Reading and Writing can be dealt with comparatively briefly. Most if not all teachers are aware of the stages in learning, but Elrond's description of experiments conducted in the U.S.A.[21] to shew the value of perceptual exercises in the case of slow readers may be helpful. Writing is hard work in bed but typewriters are fun to use and motivate children to express their feelings.[22] Story writing,[23] the hospital experience,[24] museum exhibits, interesting t.v. programmes[25] and sometimes even live animals kept in hospital may stimulate children to make use of their imagination and be part of the process of assimilation of experience of which Piaget speaks.

Most children enjoy drawing and most hospital teachers provide the opportunities for it but a teacher can be of greater help to children if she has some understanding of the different stages through which children's drawings progress. The researches of Jacqueline Goodnow[26] and Kenneth Lansing[27] are particularly helpful in this respect. Goodnow describes very clearly how children under 9 progress. She carried out experiments with 100 children aged 3-7yrs and found that even children as young as this used boundary and space rules. Each unit of the drawings had to have its own separate space. In another experiment 200 children aged 4-9yrs were asked to draw a lady with her clothes on. The eldest 67% of children drew a figure and added a skirt, the next in age drew a figure and thickened the lines to make a skirt and the youngest made a scribble for the clothes. The sequence for all was first body and then clothes.[28] Her experiments shew the teacher the importance of looking at the drawings of children of that age as a set of parts combined into a whole or pattern rather than judging them by inappropriate adult standards.[29] In writing about older children Lansing says that at about 9yrs old the child develops a conscious awareness of his own viewpoint which gives him a simple perspective. Between 9 and 11 his visual symbolisation becomes more naturalistic. From 11 - 15 he begins to deal with abstract concepts and this indicates he has entered the formal operations period and can develop concepts of space or practise drawing from natural life, and clearly there is no point in criticising visual forms such as colour expression when the child is still in the concrete operations stage.

Contrary to what might be expected mathematics is fairly popular with children in hospital - at least some parts of mathematics.[30] It requires little physical effort as compared with any other writing task.[31] It is thought to be important by children, parents and teachers. All recognise the conceptual nature of the subject. For example to work

out a telephone bill at the age of 13, it is necessary to know the multiplication tables, understand the meaning of the decimal point and handle complicated multiplication of decimals. Mathematics is also the subject on which Piaget has written most fully.[32] Here too his stress is on the 'spontaneous and gradual construction of elementary logico-mathematical structures'[33] that are to be observed, particularly in children between the ages of 7 and 11-12 years. The child often assimilates the new stage more by practical experiences than by taking in new ideas. Indeed the child is far more capable of 'doing' and understanding than of expressing himself. If the teacher is aware of the development of these structures she can arrange groups whereby children can interact with one another. The idea of organising groups of children is usually more practical in school and hospital than the idea of long individual discussions with the teacher.

An even more important point that Piaget makes in his essay on 'Mathematical Education' is the notion of how it is possible to tell if learning has taken place 'The real comprehension of a notion or a theory implies the reinvention of this theory by the subject'.[34] It is not the repeating of the subtraction sum that is the test, it is the child's inventive use of it in another way for example in a real life situation. The teacher's role is to organise situations which give rise to curiosity and to the solution of the problem using his new knowledge.

At the time of the study none of the teachers possessed a computer, but computers are beginning to be available to the teacher to her great benefit. Although still something of a rarity in the hospital teacher's equipment, it merits discussion because of its great potential particularly in relation to the style of mathematics teaching that follows from a Piagetian approach. Its most obvious benefit seen so far lies in the involvement and mathematical language children use with one another when

presented with problems to solve on the screen.[35] In the U.S.A. Professor Papert of M.I.T. has been involved with new and interesting developments. This psychologist worked with Piaget for five years in Geneva and believed that rigidly defined tasks were not Piagetian. He saw the computer as it was being used as only a more efficient way of traditional teaching. Partly in the light of his own experiences from childhood, he saw the value to children of mastering and manipulating powerful machines. This caused him to develop a new approach to computer language called LOGO. He says,

> The child does not wait with a virginally empty mind until we are ready to stuff it with a statistically validated curriculum. He is constantly engaged in inventing theories about everything, including himself, schools and teachers.[36]

Children use computers in a 'logo' environment which they direct and they 'debug'. The child gets automatic feedback from a turtle* drawn on a computer set or possibly a much more expensive variety that will roam around the floor at the child's direction.[37] The child directs the computer programmes which are structures that function. He must thereby model this structure. In learning to debug without worry he is no longer afraid of failure to learn. The teacher is available to be consulted but he does not direct the programmes. In his book 'Mindstorms' Papert explains the very difficult conceptual mathematics that the child in playing games thereby masters.[38] Especially with regard to mathematics the child absorbs and incorporates knowledge of a most valuable kind.[39] This way of using the computer emphasises the concept of children and teachers learning together. That is a concept of great importance when thinking about teaching or rather doing science in hospital. The possibilities are endless. Hospital syringes, X-ray machines, lifts, traction systems,

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* The turtle is an arrow shape drawn on the screen.

beds, pill dispensers, goniometers and drips - they are all there plus lots of other machines waiting to be investigated. If the teacher has to find out how they work all the better for learning. Interesting opportunities are at hand and these may include visits to the hospital's own computer. Thus the hospital provides many opportunities for appropriate and imaginative teaching in the main topics of a normal school education. But the concentration span of the child in hospital school is much shorter than in normal school, because of pain or external distraction. This is clearly one reason why the majority of hospital teachers allowed play in school. But is the provision of play an educational role?

Any answer to that question must be based on some understanding of the nature of play. Many theories of play have been suggested. In his book 'Why People Play',[40] M.J. Ellis examines 15 such theories, and categorises them in three groups: the old or classical explanations, the psychological theories and what he refers to as the modern theories or those prevalent since World War 2. Do any of these theories offer an account of play which might support its inclusion in activities falling within the province of the teacher?

Ellis sees grave limitations in what he calls the classical theories because each explains some types of play but does not encompass a sufficiently wide field. People play because they have surplus energy or as an instinctive drive. They play in preparation for later life or to recapitulate what they have already learnt. They play to relax. All these are true and happen sometimes; teachers would happily subscribe to notions of play as life preparation or learning recapitulation. Ellis is equally dissatisfied with the cathartic - analytic theories held by Freud and Klein on the grounds that they are untestable. They may or may not be true. Finally Ellis turns to modern theories which see play and working on a continuum and here his assessment is more favourable. "The most

satisfying explanation seems to involve an integration of three; play as arousal seeking, play as learning, and the developmentalist view of the child."[41] The concept of 'arousal seeking' needs further explanation. He defines play as 'that behaviour that is motivated by the need to elevate the level of arousal towards the optimal' while work is 'the behaviour emitted to reduce the level of stimulation'.[42] Play is stimulus seeking and work is life supporting, but they cannot validly be separated. Both activities occur at the same time. The importance of arousal in the hospital context is reinforced if the well known work of Morris (1964) on caged zoo animals is considered.[43] Children who are bored and restricted such as those who live in high rise flats (and we may add those who are kept in hospital) are found to behave similarly to the animals when driven to extremes: in their frustration they become naughty and unmanageable because they are frustrated by their low level of arousal.

Ellis goes on to cite Neumann's criteria for play.[44] Play, Neumann argues, occurs when a child controls his own behaviour, undertakes the behaviour only for experiential rewards associated with it and it is possible for him to bend some aspects of the real situation by use of his imagination. This is in line with Piaget's ideas of assimilation. Children must prepare for the unknown by problem solving and play as well as learning specific tasks such as handling money, studying traffic or writing applications for jobs. No setting can be arranged whereby a child is totally free and it is up to the teacher at any one time to decide on the appropriate emphasis. Sick children may well need an elevation of arousal without which elements of frustration and boredom will build up and make the acquisition of knowledge an impossibility. This is most readily achieved if the teacher feels able to allow a child to play while he teaches others. Discreet supervision can be maintained and after a period of play the problem solving or learning tasks can again be under-

taken. The teacher then uses play as a legitimate part of her teaching plan.

But the teacher is not alone in the use of play in hospital. It is an activity more naturally linked with the playleader. Comments on the work of the playleaders also shew ways in which play can be of great importance to the child in hospital. Hugh Jolly, the British Paediatrician who did so much to encourage play in British hospitals, wrote in The Lancet: 'Doctors and Nurses throughout the world must be made aware that play hastens the recovery of the sick child and that apathy is his worst enemy'.[45] Fifteen years later a ward sister was to write in the Nursing Times of a conversion to his view:

> Play as I now appreciate, is the child's work and is necessary for physical, emotional, intellectual, social and moral growth. There is no reason why this vital experience should be interrupted by a child's admission to hospital. There is every reason for it to be available to help him cope with a potentially threatening, frightening period in his life.[46]

In 1978 a coordinating group representing N.A.W.C.H., Save the Children's Fund, The Play in Hospitals Liaison Committee and the preschool Playgroups Association produced 'Guidelines for Play Volunteers working with Children in Acute Wards'.[47] Not only does the pamphlet say that play is the means by which the child explores the world but also that it is a means by which he reenacts experiences and expresses his fear or anger at being in hospital. A playworker is there to create the setting for the child to play in his own way; he is not just there to amuse or occupy the child. The ideas on play and work have developed into the notion of play therapy and would seem to come out of those cathartic-analytic theories of Freud, Axline and Klein, about which Ellis expressed some hesitation.

> Play Therapy ....may be described as an opportunity that is offered to the child to experience growth under the most favourable conditions. Since play is his natural medium for self-expression, the child is given the opportunity to play out his accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment,

> confusion. By playing out these feelings he brings them to the surface, gets them out in the open, faces them, learns to control them, or abandons them.[48]

In Sweden Ivonny Lindquist, a nursery teacher turned Play Therapist, has adopted and spread this view of play therapy. She includes the preparation of children for surgery as part of her role.[49] In the U.S.A. where the play therapists have often had extensive training for their role, e.g. four years at Wheelock College, Boston,[50] the child life movement has made extensive use of the work of the analysts. Jane Brody in an article in the New York Times, entitled "New Focus on Emotions of Child in Hospital,"[51] wrote of the experience of children in a number of different hospitals. In Minneapolis "Play Therapy is used to help children express their feelings, act out their fears and anxieties, learn about their illness and maintain a sense of control over their lives." There is a belief among members of the child life movement that children helped with their emotional problems recover more quickly, but, as Ellis has commented, the design of any experiment which could test such a prediction is in practice almost impossible. The length of stay of children may appear to be reduced; but that has also been the case in Britain for reasons other than the introduction of play therapy.

Both British and American playleaders are charged with the task of getting to know families and of observing and/or recording special or unusual activities occurring during play. In the U.S.A. they often attend case conferences and give talks to hospital staff. It can readily be understood that this approach to play which is usually undertaken with individual children leaves little time for the more general and educational task with which the teacher is likely to be concerned.

It has been necessary to discuss play and the work of the playleaders at some length because hospital teachers, faced with children of all ages and unable to hold Mabel Schulen's view, have felt very uneasy

that they too may be labelled 'Those who just play with children'. But if the account that has been developed is correct, it is clear that while there is an important play role for the trained play therapist, 'optimum arousal', which is a basic human need, is the task of the teacher, and to this end the teacher needs to use play as part of the whole play-work continuum. Play and education and art are inseparable.[52] Children who are sick weave in and out of needing them. Play may precede an hour of mathematics. There can be no rigidity of time tabling; pain and illness do not allow it. These are sick children not just normal children keeping up with their lessons. These guidelines on what may be appropriate education for children in hospital have to a large extent been developed from Piaget. They have given rise to a view of the teacher who may be described as a knowledgeable and understanding catalyst - an organiser who can motivate sick children and enable learning to take place. Such an approach is clearly favourable to seeing the wide range of activities undertaken with children by hospital teachers - even including forms of play - as part of a proper educational role.

But it may still be asked whether there are not more formal procedures that may be followed to discover whether genuine learning has taken place. Could this be shown by a process of testing? The most extensive use of tests is to be found in parts of the U.S.A. Monthly tests, as sometimes operated there, tend to result in all energies being concentrated on the one goal of increasing test scores.[53] But even where testing is not carried to these undesirable extremes, its value is less clear than might be expected. Its limitations even in relation to such a subject as mathematics are stressed in a discussion paper in the D.E.S. HMI Series.

> It is essential to know the ability of the child to apply skill and knowledge to problems associated with the world in which he lives, the teacher needs to know the child's attitude towards mathematics, his perseve-

> rance, creativity (elaboration, fluency, flexibility and originality), his understanding, visualisation and psychomotor skills....Formal examinations based on syllabus content, frequently limit the teaching of mathematics to that which is to be tested.[54]

The limitations of testing are bound to be even greater when children are under stress in hospital. Moreover teachers in this study showed themselves unwilling to test children on entering hospital. Thus the unsatisfactory character of the testing process, together with the particular difficulty of operating such a procedure with sick children, show that there is no way forward along those lines.

Are there any less formal processes of evaluation, which might help to determine whether children have achieved any increase in knowledge as a result of the education given? Reference has been made to the Oracle research.[55] The Oracle researchers considered the problem of what constitutes 'work'. They thought that what counted as work was a qualitative judgment[56] and that "in both science and educational research, objectivity is little more than the outcome of shared subjective agreement and to this degree the procedures of both may be objective."[57] In Britain those best placed and equipped to produce shared subjective agreement would seem to be the H.M.I.'s During the past year their reports on school visits have been available for perusal. Two junior school reports have been selected at random and it is interesting to read in these of the conclusions reached by the Inspectors.

Of Windy Nook Junior School they had this to say:

> Opportunities for pupils to discuss and extend their own ideas, to experiment or to write at length, however, are limited and their ability to converse fluently and confidently is under-developed. The school offers a wide range of subjects but too much time is given to closely directed repetitive tasks which do not meet the needs of the children.[58]

These are general comments which represent one third of their conclusions. They would seem to underline the need for the teacher to be the

enabler or catalyst for children to make the transition between book knowledge and action knowledge. Of Lonesome Primary School, Mitcham, they said

> The good practice to be seen in some classes clearly indicates how children's experiences can be enriched and exploited as well as recorded in a variety of ways. These classes also show how the special needs of children can be met through the organisation of some small group teaching so that there is a maximum interaction between teacher and children. The commitment and caring attitude of the staff together with the expertise that is available already, indicate that it is well within the capacity of the school to develop this good practice further.[59]

These comments make up nearly half the conclusion and again show how the Inspectors feel about enrichment and exploitation of children's experiences and about the benefits to be gained by the interaction of teachers in the small group situation. The Inspectors in these reports seem to be concerned not with testing but primarily with a qualitative evaluation. One H.M.I. writing out of many years experience in the inspectorate,[60] suggests that one could give more precision to the process of evaluation by seeking to answer the following three questions:

1. Did the children learn anything?
2. Did they learn what the teacher would like them to learn?
3. Did they learn what it was desirable they should learn?

The answer to the first question is unlikely to be other than 'Yes'. But the second and third questions may help to clarify the issues to which any evaluation of teaching in the hospital context needs to pay attention. If the children are to learn what the teacher wants them to learn, adequate provision is virtually essential. This will take the form of support from the hospital staff, support from the education authority, suitable equipment, suitable help (playleader, volunteer) and a suitable environment. But in addition to these external factors it is necessary to look with even more care at the response of the children. Is there a good

oral response between children and teacher? Is the written work copied or original? Is the practical work undertaken creatively? Are all the children actively involved? Finally the question whether the children are learning what it is desirable they should learn prompts a further series of questions. Is there a broad curriculum of subjects? Is remedial work based on purposeful assessment? Are hospital studies included? Do teachers have schemes of work for long-stay pupils? Are creative activities included? Do discovery and invention play a part?

In the light of the Piagetian approach to education and the type of evaluation that has been described, it is now possible to consider how to judge the work done with the children that was observed in this study. The evaluation will be concerned with the British wards only and will pay separate attention to the two groups of longer-stay and short-stay children. 'Long-stay' has not been defined in the study as it was not known to the observer when a child would leave the hospital, a child will be treated as long-stay for the purpose of this discussion if he has already been in the ward for a week.

Summary

Particular activities of the children have been classed as 'positive learning' activities. There are some activities undertaken by children in schools, such as completing pages of sums or grammar exercises, which may be thought of as 'proper school work'. In viewing the curriculum it is important for teachers to have a philosophy of education which enables them to understand what 'proper work' might be in a hospital context.

The guidelines of Piaget are applied to see what could be meant by an educational role in the context of the hospital. The child's concept of his illness and the developmental stages of learning art, mathematics and science are discussed. The computer and its problem-solving potential

is considered. Photographs and children's work are used to illustrate how Piaget's guidelines might be put into practice in the hospital. Teachers had disagreed on whether to allow play in school, and theories of play are discussed with the conclusion being reached that 'play' is a legitimate means of arousal of the child and is to be integrated with periods of 'work'. This is a different use of play from that of the child life worker who has a training in psychology.

Consideration is given to means of evaluation of hospital teaching. Assessment test are thought by teachers to be invalid in a hospital context, and attention is paid to the conclusions of H.M.I.'s in their recent reports on schools. The active involvement of the children, the suitablility of the tasks undertaken by them and the intercommunication between the teachers and the pupils are seen to be important.

Appendix 1 - Children at Work

A. A poem written in the U.S.A. by Michael (9)

Things I don't like

I don't like the whole place

The food

The one position I have to stay in

The pain.

Not all kids have the same pain. I wish

I could walk around. Some

Kids can walk around or ride

Wheelchairs. I wish I could.

I don't like I.V.'s

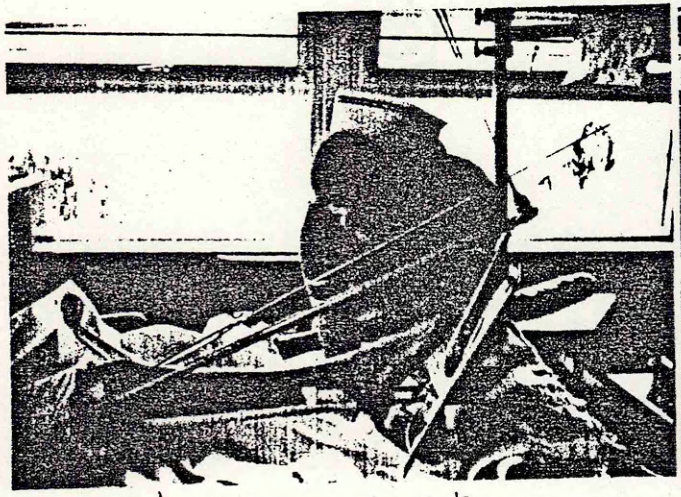
I don't like some of the nurses

I don't like shots

The other kids screaming

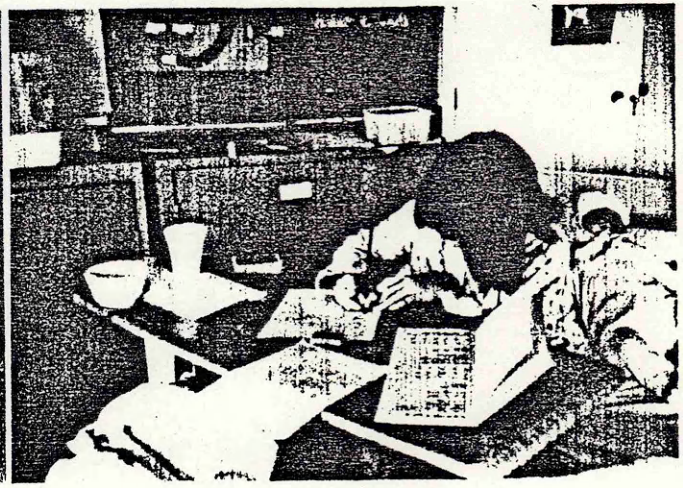
And if anyone thinks it would be neat they can take my place.

(Written with the help of a c.l.w.)



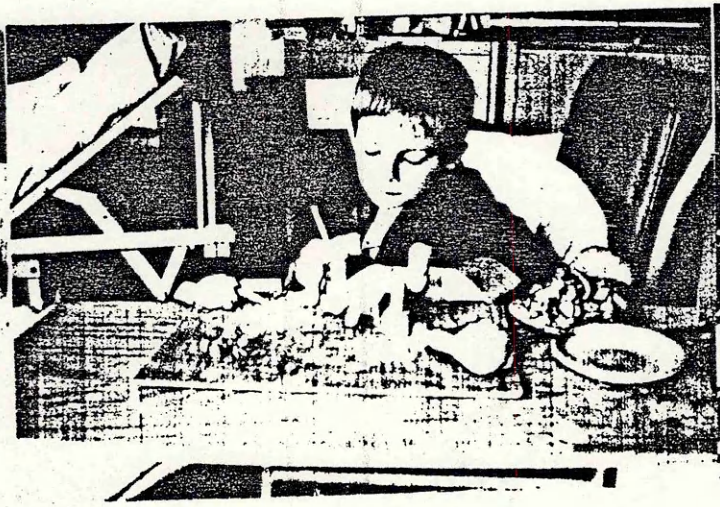
B 'Feet'. Follow up of t.v. programme

C 'Pirates gold' Mathematical game



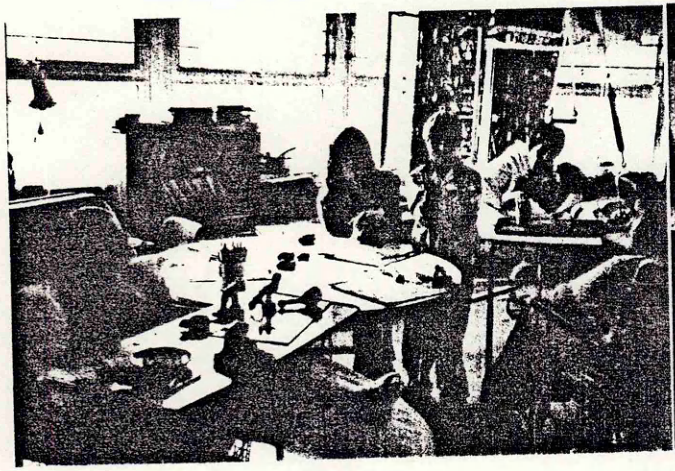
D. School work

E Typing a story



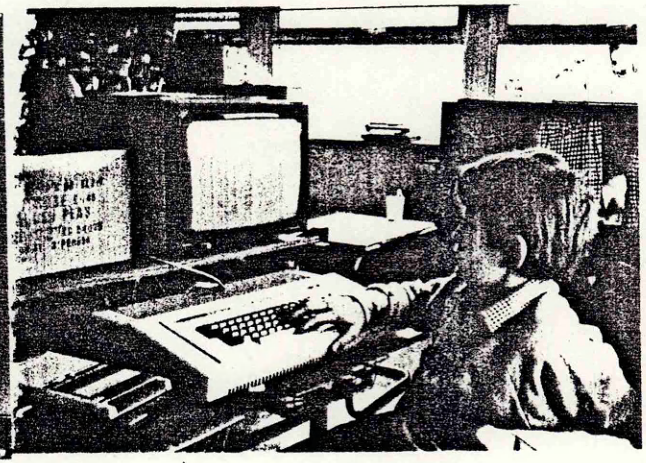
F Modelling clay bones in clay.

G 'A 4 yrold learns shapes.

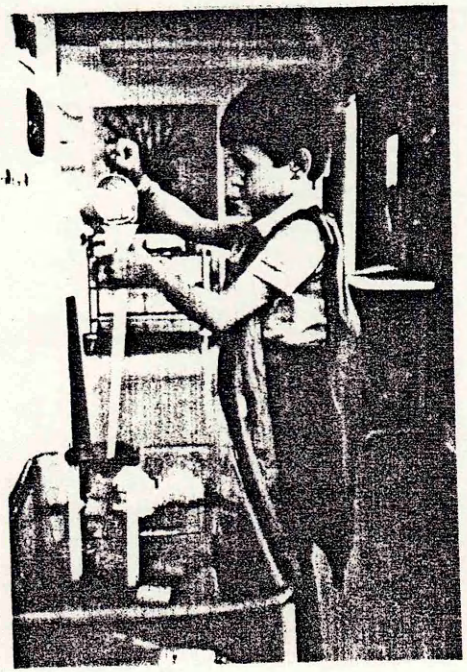


H. Art and Craft.

I. A puppet play

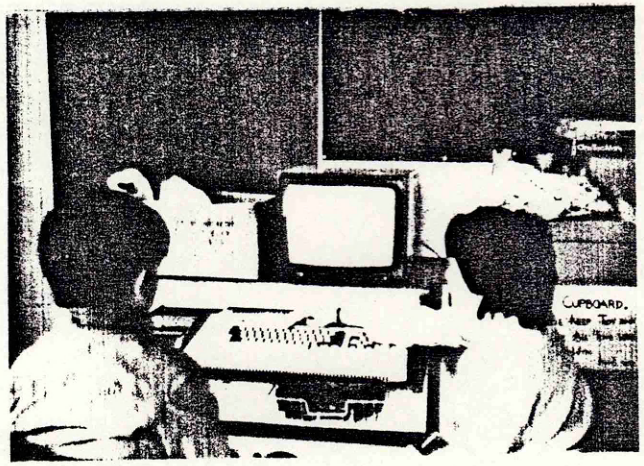


J. 'Arrow' - a logo type programme



K. Play in school

L. John's mask.



M Discussing Mathematics.

N.

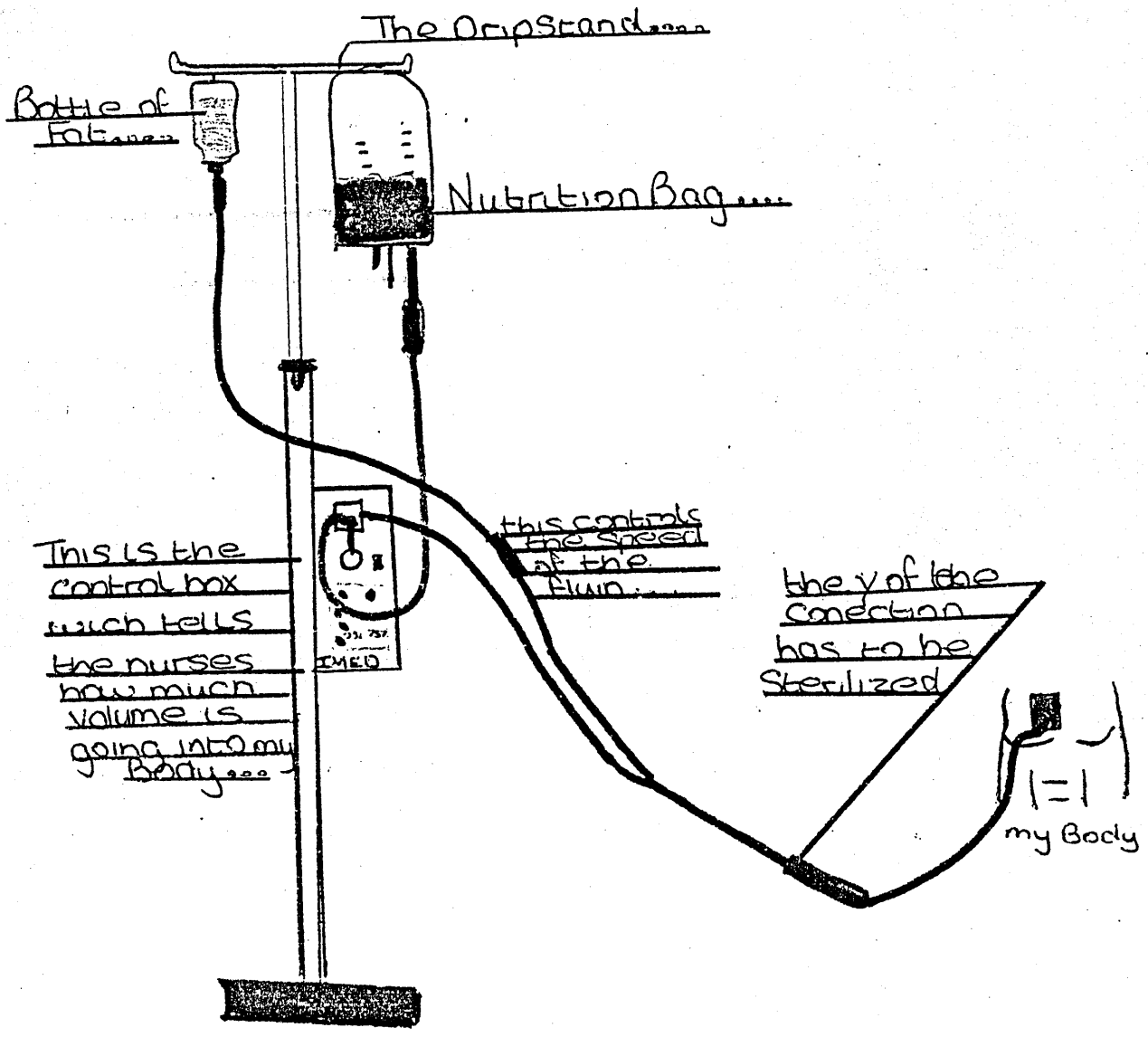
IMED 922 VOLUMETRIC INFUSION PUMP

THE IMED 922 VOLUMETRIC INFUSION PUMP, WORKS BY MAINS OR BY BATTERY. THERE ARE TWO BAGS ON A DRIPSTAND. ONE OF THE BAGS HAS IRON, NITROGEN, DEXTROSE, SODIUM, POTASSIUM, MAGNESIUM, CALCIUM, PHOSPHATE, AND CHLORIDE. THIS JOINS TO ANOTHER BAG WHICH IS FILLED WITH: SOYA BEAN OIL
SOYA PHOSPHATIDES
GLYCEROL.

.....

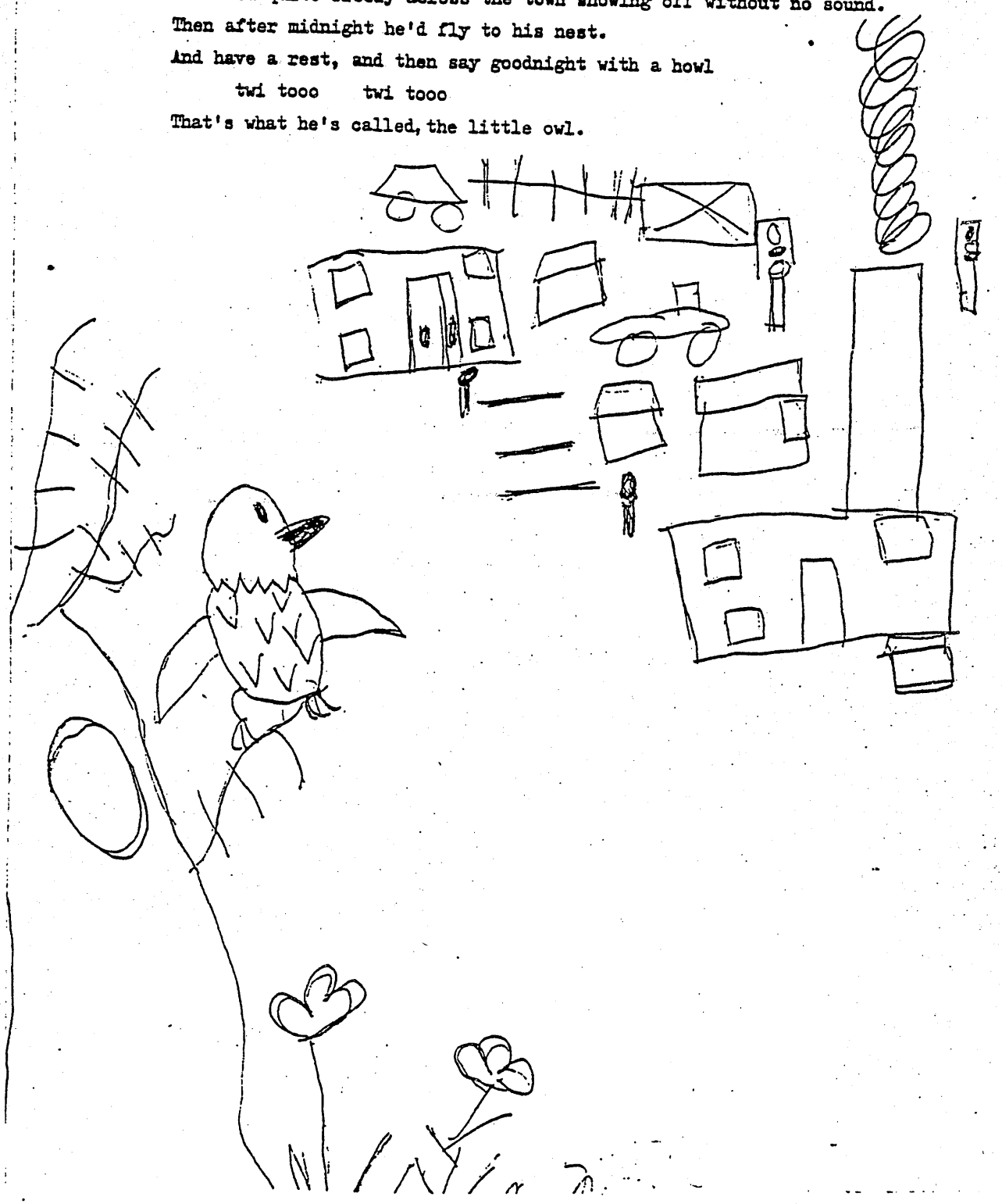
THE TUBE FROM THE NUTRITON BAG GOES THROUGH THE PUMP TO GET RID OF ANY AIR BUBBLES. AFTER THE PUMP THE TUBES JOIN AND ENTER MY BLOOD SYSTEM

.....

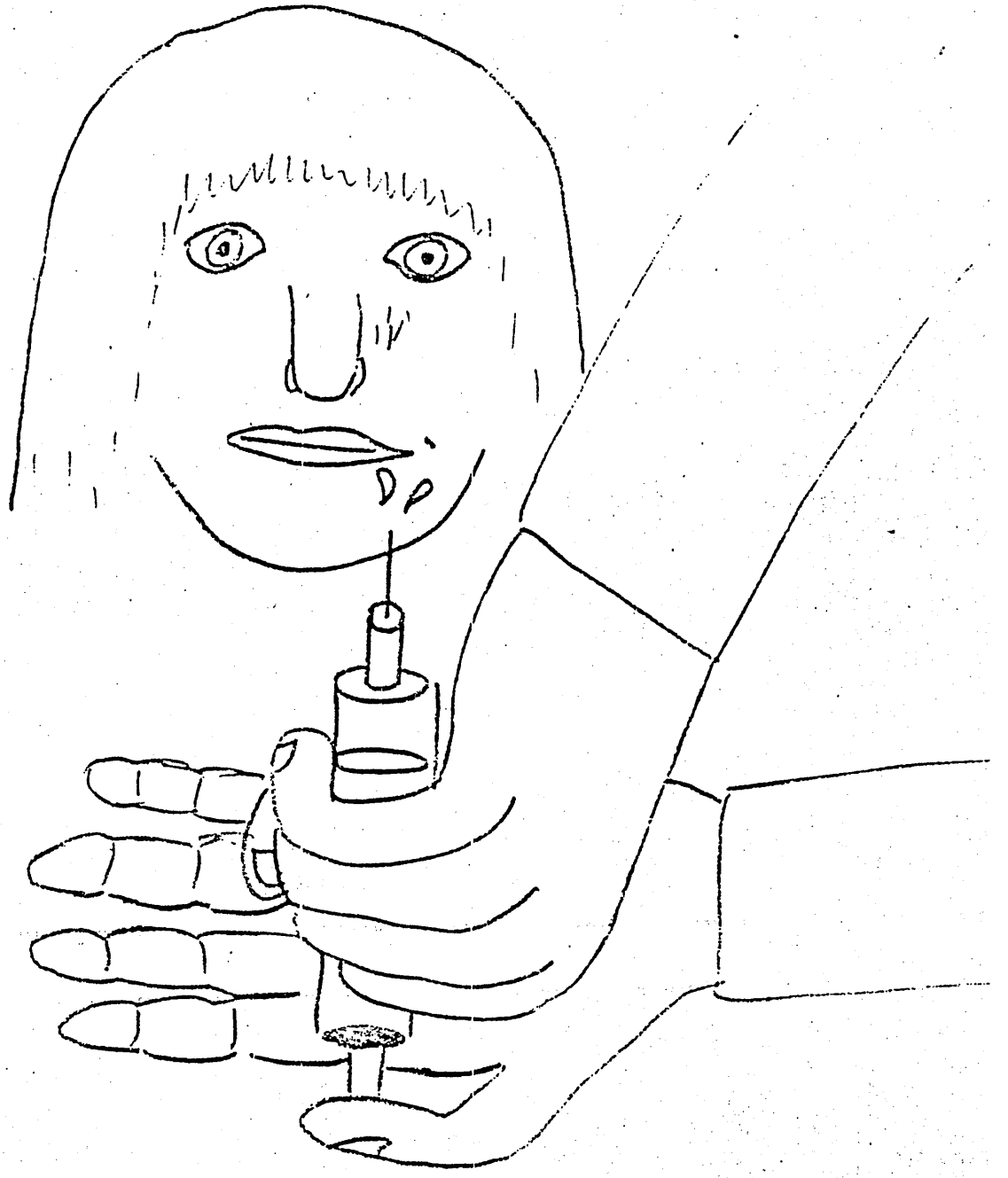


THE LITTLE OWL

The little owl came out at night.
And he loved the wonderful height.
He jumped on the chimney tops, and flyed in the air.
And there was nothing that he wouldn't dare.
He lived quite freely across the town showing off without no sound.
Then after midnight he'd fly to his nest.
And have a rest, and then say goodnight with a howl
twi tooo twi tooo
That's what he's called, the little owl.



P.



The Worst Part

By Richard

The hospital routine

Tick, tock, tick, tock,
Everything's like an electric clock,
Clean, clean,
Everything gleams

P.

To my Mum, Here is a poem for you:

When I sit in my room,
I feel so bored and full of gloom.
All I do is to read my comics or perhaps watch telly.
But everyday I feel like jelly
Sitting in my room.

Renna (12)

Neither the poem or the subject had been suggested to Renna. The next day because he had written this poem he was asked if he would also like to write a poem about school in the mornings in the playroom. There was no school in the afternoons and the playleader had been away on holiday.

The Playroom

The playroom is where we stay, pity its only for half the day.
We play games, write, and have such fun, what if we did not have it? Oh, that would be the worst thing to say.
But one thing I can say, and that is,
it makes my day'

Φ

Prince Charles and Lady Di are portrayed with joy but Jacqueline's confused feelings then became evident - "dangerous animals".

~~happy di~~

This is the most beautiful PRINCESS in the world

Jacqueline.

References

1. Groen G., 'The theoretical ideas of Piaget and educational Practice' In Suppes. P.(ed.) 'Impact of research in education' National Academy of Education, Washington (1978), p.288.

1a. Since Piagetian ideas underly much current educational practice, their significance for this study is unaffected by the theoretical debates about the work of Piaget, particularly in relation to the connection of developmental stages to particular chronological ages.

2. Maier H.W., 'Three theories of child development', revised ed. Harper and Row N.Y. (1969), p.155a.

3. Bruner J., 'The process of Education', Harvard Univ. Press, (1963).

4. Welty E., 'Delta Wedding' Virago (1982).

5. Ibid., p.103-104.

6. Brewster A., 'Chronically Ill Hospitalised Children's Concepts of their Illness' in Paediatrics 69:355 (1982).

7. Bibace R., and Walsh, M., 'The development of Children's concepts of Health and Illness'. Paper delivered to the American Psychological Convention, San Francisco, Aug. (1977).

8. See above ch. 1. p.12.

9. Sturner R., et al., 'The Routine 'Well Child' Examination', Clinical Pediatrics, Vol. 19, No. 4, April (1980).

10. 'Report of the Working Party on the Changing Role of the Registered Sick Children's Nurse and the Implications for Training' (1979) p. 3, General Nursing Council 79/11/1.

11. Hawthorne, P., 'Nurse, I want my Mummy', R.C.N. (1974), p.65.

12. A.C.C.H., 'Guidelines for the Development of Child Life Programs', (1980).

13. See above Appendix 1A, p.162.

14. Op.cit.(7), p.1.

15. Elrond D., 'Children and Adolescents' 3rd ed. O.U.P. (1981) p.48.

16. Ibid., p.34.

17. 'Piaget and British Primary Education' from Educational Psychologist (1974) 11; reprinted D. Elrond Op.cit.(15). p.204.

18. See above Appendix 1F, p.163.

19. See above Appendix 1N, p.165.

20. Op.cit.(17), p.213.

21. Op.cit.(17), p.169, 186.

22. See above Appendix 1E, p.163.

23. See above Appendix 1O, p.166.

24. See above Appendix 1P, p.167, 168.

25. See above Appendix 1B, p.163.

26. Goodnow J., 'Children's Drawing'. Open Books London (1977) (ed. series Bruner J., Cole M. and Lloyd B., 'The Developing Child').

27. Lansing K. M., 'The Research of Jean Piaget and its implications for Art Education in the Elementary School' in ed. Athey, I.J. and Rubadeau, D.O. 'Educational Implications of Piaget's Theory', Ginn Co., (1970).

28. Op.cit.(26), p.67.

29. See above Appendix 1Q, p.169.

30. See above Appendix 1C, p.163.

31. See above Appendix 1D, p.163.

32. Gruber,H. and Vaneche, J.(eds.), 'The Essential Piaget', Basic Books USA (1977), pp.702-704 (From Piaget's 'Science of Education and the Psychology of the Child', 1965).

33. Ibid., p.726-727 (from Piaget's 'Developments in Mathematical Education', 1972).

34. Ibid., p.731.

35. See above Appendix 1M, p.164.

36. Papert S., 'Teaching Children Thinking' in 'Programmed Learning and Educated Technology 9(S)', (1972), pp 245-6.

37. Papert S., 'Mindstorms'. Basic Books, New York (1980).

38. Ibid., pp.55-94.

39. See above appendix 1G (p.163) and 1J (p.164).

40. Ellis M., 'Why people play', Prentice Hall (1973).

41. Ibid., p.119.

42. Ibid., p.110.

43. Morris D., 'The response of animals to a restricted environment', Symposium of the Zoological Society, London (1964), 13:99 - 118.

44. Neumann E., 'The elements of Play' unpublished doctoral dissertation, university of Illinois, 1971, cited by Ellis M.J., op.cit.(40), p.125.

45. Jolly H., 'Play is work', Lancet 2:487 (1969).

46. King S., 'The Story of a Convert', Nursing Times Jan. 4 1984, p.56.

47. P.H.L.C., 'Guidelines for Play Volunteers working with children in hospital in acute wards' (1978).

48. Cited by Ellis M.J., op. cit.(40), p.61.

49. Lindquist I., 'Therapy through play', (Swedish Edition 1970), Arlington Books (1977).

50. See above Ch. 5.p.111.

51. Brody J., 'New Focus on Emotions of Child in Hospital', New York Times, Sept. 21st 1982, p.cl.

52. See appendix 1H, 1I, 1K, and 1L, p.164.

53. Gipps C., Steadman S., Blackstone T., and Stierer B.,'Testing Children'. Heinemann Educational (1983) p. 131.

54. D.E.S. H.M.I. series, 'Matters for Discussion', H.M.S.O. (1979), p.10.

55. See above Ch. 3, p.32.

56. Galton, M., Simon B., Croll P., "Inside the Primary Classroom". Routledge and Kegan Paul (1980) p.28.

57. Op.cit.(56), p.171-4.

58. D.E.S. Report by H.M.I.'s 5350/2203/01 (1984) p.13.

59. D.E.S. Report by H.M.I.'s 5315/2064/01 (1984) p.21.

60. 'Three Questions' from private correspondence with an H.M.I. (1984).

Chapter 7

An Educational Assessment of the British Wards

The need to provide some sort of education for long-stay children in hospital is not under challenge. It is the way in which it is provided that is open to question. Mabel Schulen saw specific advantages for children in the provision of a tutorial system and regarded the inclusion of other children in the provision as diversionary.[10] She was able in a specialist children's hospital and with a large staff to negotiate periods of tutorial time in which a child could be free from interruptions of treatment or visitors and could concentrate on his own school studies.

The importance to a child of having his own tutor is undeniable but some of the problems which necessarily occur for a tutor working without benefit of support in a general hospital were apparent in this study. On ward A, John was a recurrent pupil in the hospital and he had three tutorial visits. He tried to write on his bed table but it was too high for the purpose and there seemed to be no alternative. John could have sat in a chair at a table but no one told the teacher, so he stayed uncomfortably on his bed. On one visit he was constantly interrupted by a three year old. In the middle of another visit a nurse arrived and inserted a drip in his arm and then told him to just carry on. He cried. This was not an easy situation for the teacher who was after all only a visitor to the hospital. David aged 7 was to stay in the hospital for 6 weeks and had a tutor for 5 hours a week. During these sessions he worked at his school maths and reading book and he played educational games with the teacher. All of these things he enjoyed. Unfortunately there was a great deal of time left over in which he seemed very bored. There was no equipment or facility for creative occupations and no playleader to lead

the play with the many toys which were available. The lack of sustained play on this ward which was full of toys was an example of the need for hospitals to employ playleaders as well as teachers.

On ward B there were more long-stay and recurrent children and four of these were asthmatics who needed treatment during school hours. Because on this ward school continued all the morning no special arrangements were necessary for tutorial instruction and children could quickly resume work after treatment even if several periods of treatment were necessary. All children were included in school and this meant that a near normal school atmosphere prevailed. There was a reasonable amount of books and equipment so that the children's own books could be supplemented and the work enriched. Long-stay children were seen to read, use English workbooks, do mathematics, make cards, complete jigsaws, write letters, play matching pairs games and copy pictures. The orderly scene that was observed on each morning of the visit led to the conclusion that a child who was on this ward would have the benefit of daily tuition in the company of other children and, even though he would be doing similar tasks to the tutored children on ward A, the occupations would continue for the entire morning instead of for one hour. For children who must pass the whole day and night in the same room, the benefit from the presence of a teacher was the opportunity for sustained normal activity. The external factors were all helpful and the children were involved with their work and with the teacher. French was taught but it must be said that otherwise the curriculum seemed limited, and during the study work of a practical or creative nature consisted almost entirely of jigsaw puzzles (often maps) and cardmaking. Pictures were copied by older children and only a few were drawn without assistance by the younger children. Hospital studies and reports played no part and there was nothing

in the way of discovery or invention or any input from schools television or from external sources such as the museum.

Mabel Schulen was concerned that the teacher might be distracted by the needs of the short-stay children.[2] This was not the case during the study and the presence of a nursery assistant made it seem unlikely that additional children would have changed the situation. The short-stay children, after discussion with the teacher, were given appropriate and similar tasks to the others and they too worked hard all the morning. Parents commented to us on the benefit of the tuition to their children.

On C there were organisational problems with a small schoolroom and several venues for the children. There was no question of moving beds because there would have been no room for them in the schoolroom. On four visits there were two acting teachers so that children on the wards as well as those in the schoolroom could receive attention. On the fifth visit an asthmatic child who had to stay in bed wanted to paint but she was not allowed to do so in the absence of the teacher. She did not feel like reading, so spent the morning lying unoccupied. A volunteer would have been very helpful in this situation, but as on B, there was none. However on several occasions the playleader occupied seriously ill school age children who were on the ward or who were isolated in one of the side cubicles.

All mobile children attended school in the schoolroom and an 8yr old with a chronic bowel problem, who found concentration very difficult, was persuaded to join in school by the encouragement of two 13yr olds. The chief occupations in school were reading, mathematics, geography, spelling and story writing using children's own interests. Group games usually ended the sessions. A popular game was pelmanism using months of the year and days of the week. In addition there was a special art teacher

and the interest of the children and the involvement of the very seriously ill in the model making that occurred was heartening.

Except for a few of the bed bound the children were all involved and the curriculum seemed to encompass many of the children's interests but there was no science, French or hospital studies. Creative activities were much in evidence in the schoolroom and the walls of the ward were filled with outstandingly good pictures inspired by both the playleader and the teacher. The short-stay children joined the long-stay in similar activities. The small schoolroom was conducive to good discussions between children about their subjects of interest but there was no room in it for beds or visitors. An alternative might have been to use the large empty playroom for school. There could be a problem on this ward if there was only one teacher, for there was a clear need for assistance.

On D, as on B, there was an assistant to the teacher. Most of the other factors were different. There were more long-stay children and more children needed nursing attention during school hours. Children were to be found in more ward areas and school started 10 mins late because of the problem of moving the children to one area of the ward, namely the playroom. B, C and D had similar size playrooms but on D, unlike B or C, there was no alternative space available. On D the playleader helped if there were no younger children (during the visits there were always younger children needing attention) and, in addition, a volunteer and several parents were usually at hand to assist but the vulnerability to interruptions was clearly shown when an upset mother involved the entire room. As on C the walls were full of pictures to which a number of children had contributed. There was a greater range of equipment and the television set was in use on each visit. The programmes viewed were History, Merry go round (including a programme on feet), Science and Music Time. Children would have been viewing some of these programmes in

their own schools and some attempt was made to follow them up with experiments, microscopes, and booklets. Not all children took part and some played with a toy hospital or lego or mastermind. Many children were asked to contribute to a book of 'Animals' which was to be presented to the ward sister. A squirrel from the museum provided a topic for drawing and study. Some of the mobile children paid a visit to the hospital computer which had several programmes available for the children. Two typewriters were available to aid writing and 'Speak and Spell' and 'Speak and Maths' electronic games were in constant use. Several children had their own school maths books and others used apparatus such as a cash register to do practical work or played games such as 'pirates gold' if they were younger.

The range of activities was wide and the programme would have been difficult to carry out if volunteers and parents had not been available. Since children were sometimes in pain following accident or surgery it was necessary to switch to less demanding activities when it was appropriate. Mabel Schulen's hypothesis could have been true - one teacher by herself would have been in a difficult if not impossible position in trying to cope with the needs of so many immobile children. Long-stay children who had their own school books worked at these. The others were motivated by similar activities to the short-stay.

In the afternoon there was little provision of activities for children on A and on C. On B the playleader arrived with a trolley full of games. When she herself was able to be involved or if nurses were involved, the games were successful. On one afternoon she was completely monopolised by a 2yr old and then the same situation occurred as had occurred on A; the children changed their games constantly. One afternoon the children were very actively involved. Seven children aged 2-13 modelled with playdoh for half an hour and 5 of these (4 of school age)

spent a long time before and after the modelling playing doctors and hospitals. It was clear that the playleader alone could not attend to the needs of all children when there were several toddlers.

On D the teacher had the help of the playleader and ward assistants which was necessary considering the number of immobile children. Children cooperated and chatted while they worked and while Christmas Decorations had a limited appeal for some of the boys, the cooking and the pottery and the plaster modelling had the involvement of all. The teacher had the equipment necessary to undertake these tasks and the necessary skill to handle the materials and more importantly to stimulate the children. A change in the timing of afternoon school might have made the sessions less frustrating for the teacher.

In comparing the afternoons on B and D, it must be said that the nature of the occupations were in general more creative on D, and, while the playleader might suggest games for the school age children, the teacher may have been regarded as more authoritative and her suggestions were usually heeded. This is not to imply that she was rigid. A boy who decided not to make decorations was accorded his incessantly expressed wish which was to play doctors and nurses.

A view has been presented of the quality of the children's work on the wards. The Inspectors could be said to have been looking for 1) involvement of the children and 2) appropriate activities of a stimulating nature. The children were involved and the teachers were communicating with the children during all of the available time. The nature of the occupations on B and C were similar to those that could be encountered in many junior schools. However there was no free play and there were no pictures or writing about the hospital. Jigsaw puzzles were popular and these are in the nature of a problem solving task. Creative writing and art were much in evidence on C and on D. On D there was a

much wider variety of occupations and these included practical mathematics and science. The children gained from the presence of a teacher all day.

While the qualitative evaluation of a study must be a subjective view, all of the children appeared to gain from the normality of the experience and it was normality that the teachers were attempting to provide. However, the majority of the children in hospital are of course short-stay and, while it is true that short-stay children may actually be at home and away from their own schools for quite a longtime, the argument for their education in hospital cannot be based on the fact that they are failing to acquire factual information; this is a general hazard of school years and the work can often be made up. In this study, short-stay children have been seen to be involved in learning alongside the long-stay children and this has made the position for the long-stay children much more normal. An individually tutored child is not being taught normally; the group is normal. While the teacher time allocated to any one child must be reduced, the length of stay under teacher supervision has been greatly increased. With the exception of Maria, the longer-stay children in this study have benefited from the presence of the shorter-stay, for when in groups the children often stimulated and involved one another making concentration and attention much longer. The real benefit to the short-stay children derives from teachers who believe with Piaget that they are there to give children the opportunity to represent their experiences; and it must be remembered that the majority of children enter hospital because of accident and injury and their experiences will never be forgotten. The teacher carries out a normal school programme for the benefit of the long-stay children. If that programme contains a variety of problem solving tasks, science, creative writing and art and craft in a variety of forms, the imagination and

interest of the children can be captured and they will be in a learning environment in which they will be able to represent their experiences at the same time growing in knowledge and ability to learn. As John Holt says in the summary to his study of how children fail, 'It is not subject matter that makes some learning more valuable than others, but the spirit in which the work is done'.[3]

Educational researchers are harshly described by Cedric Cullingford, editor of a series of books on children and learning:

> They concentrate on curriculum, subject matter, never on insights into the way children learn. They treat children as measurable objects as if they were rats.[4]

The Oracle study avoided those pitfalls and studied both teachers and pupils in the classroom situation. In the final book of the study the researchers wrote:'The weight of evidence from all the studies undertaken as part of the Oracle programme point towards the conclusion that it is the interactions which take place between the teacher and pupil which are the most important determinant of pupils' progress'.[5] These positive interactions were far more important than any other factors such as type of classroom, class size, time spent on tasks, social class and curriculum which they investigated. They describe teachers who were successful:

> These teachers cut down the time spent in managerial and disciplinary instructions. They were less didactic, asking more challenging questions, suggesting more ideas and giving pupils more feedback concerning the quality of their work. To summarize, they spent more time talking with pupils rather than talking at them when compared to their less successful colleagues.[6]

It is to be hoped that in this study also Cullingford's strictures have been avoided. In relation to hospital teaching it is particularly important that this should be so. The complexity of the hospital teacher's task in making educational provision for all children age 5 - 16 is vast. The teacher needs imagination and insight into the needs and thinking of children. In the spirit of Emily Dickinson's delightful poem, it may even

be said that where the support, assistance and equipment are meagre, insight can still achieve much.

> To make a prairie it takes clover and one bee
> One clover, and a bee,
> and revery.
> The revery alone will do
> If bees are few[7]

Summary

An assessment is made of the educational provision for each of the British wards in terms of the guidelines which have been developed in the previous chapter. The position of short-stay and long-stay children is reviewed and consideration is given to some of the difficulties for the long-stay child even when a private tutor is provided. The normality of the group situation with its common work ethic, the opportunity provided for creative expression, and the stimulation offered by the teacher are seen as major benefits of a teacher being provided for all the children.

References

1. Any comparable educational assessment of the American wards would require more informed consideration of American practice in schools than could be attempted in this study.

1a. See above Ch. 1, p.12.

2. See above Ch. 1, p.12.

3. Holt, J., 'How Children Fail', Pelican Books (1969), p.175.

4. 'Starting at Home', Oxford Times, July 20 1984, p.12.

5. Galton, M., and Willcocks, J., (eds.), 'Moving from the Primary Classroom', Routledge and Kegan Paul (1983), p.181.

6. Ibid., p.187.

7. Johnson T. (ed.), 'The complete poems of Emily Dickinson', Boston: Little Brown and Co., (1960), p.710.

Conclusion

Fassam showed the inadequacy of provision of teachers for children in hospital in some parts of the country and the need for a national policy. Most children stay in hospital for only a short time but some stay for a long period and others return intermittently. There is a long tradition of teachers being appointed to work on children's wards and where there is no teacher appointed some long-stay children are assigned a private tutor.

This study shews that in practice the provision of a visiting tutor is not an adequate way of providing education for children in hospital. It also shews that volunteers, parents and playleaders are not able to undertake this role.

Teachers should be appointed to all hospital wards where there are 12 or more beds for school age children. Even if they work on the ward part-time they can operate as members of the ward team and provide a near normal, work-oriented atmosphere for all of the children. This is greatly to the benefit of the long-stay and recurrent children as well as the short-stay children. Within the normal situation of a group of children the teacher can provide the stimulation, the opportunity for creative expression, problem solving and remedial teaching that are essential for educational progress. This can be seen as a therapeutic process for the child which enables him to cope with the stress and return as quickly as possible to his own school. The teacher is an important link in the passage from school to hospital and the return to school.

The task is not easy for the teacher who must relate to the whole school age range. A training in social skills, an understanding of disease and its patterns and an ability to gain the support of parents and hospital staff as well as an understanding of the concerns of

neighbourhood schools would seem to be necessary. The support of the education authority is basic.

It is difficult to evaluate the therapeutic role of the teacher but psychological theories of coping and psycho-sociological theories of crisis intervention are relevant and could provide studies for further research. In this research it has been sufficient to shew that the role of the teacher is educational, but it is to be hoped that it will also be viewed as therapeutic.

Appendix 2

TEACHER QUESTIONNAIRE

Please ◯ chosen answers

1 How long have you been teaching in a hospital ?	0 - 1 years	a
	2 - 4 years	b
	5 - 10 years	c
	11 or more years	d
2 Which of the following did your mainstream teaching include ?	Secondary	a
	Middle	b
	Primary	c
	Infants	d
	None	e
3 For what period is teaching available on your ward?	Mornings and Afternoons	a
	Mornings only	b
	Only when required	c
4 When you started work did you have an opportunity to discuss your job with the ward Sister ?	Yes	a
	No	b
	Incidentally	c
5 Do you write in the nurses cardex (daily ward notes)	Sometimes	a
	Never	b
6 Have you had any regular volunteers (Other than nursery nurses in training) to help you in the last 12 months ?	Yes	a
	No	b
7 Do you have a staffroom ?	Yes	a
	No	b
8 Do you have a T.V. for use with the children ?	Yes	a
	No	b
9 State what age range you teach in hospital now.		
10 In the last 3 years have you or a colleague arranged tuition for a patient on an adult ward ?	Yes	a
	No	b

11 Have you talked to a Social Worker about a patient in the last 12 months ?	Yes	a
	No	b
12 Do you or a colleague request arrangements for Home Teaching when a patient needs to convalesce at home for a long time ?	Yes	a
	No	b
13 In the last 12 months have you written a report for a doctor ?	Yes	a
	No	b
14 In the past 5 years have you ever arranged an invigilation for an examination ?	Yes	a
	No	b
15 How often do you do projects with a group of children ?	Twice a week	a
	Weekly	b
	Once a month	c
	Never	d
16 How often do you meet colleagues from other hospitals ?	Several times a term	a
	Once a term	b
	Occasionally	c
17 Have you visited a mainstream school within the last years ?	Yes	a
	No	b
18 Do you feel yourself to be a member of the ward staff as well as a teacher ?	Yes	a
	No	b
	Don't know	c
19 Would you like to have a closer link with the ward staff ?	Yes	a
	No	b
20 In the last 2 years have you taken a child to visit other parts of the hospital ?	Yes	a
	No	b
21 In your hospital is a teacher employed in the summer holidays ?	Yes	a
	No	b
22 Do you think a teacher should be employed for some part of the holidays ?	Yes	a
	No	b
	Don't know	c

23 Are you ever invited to social events with the hospital staff ?	Yes	a
	No	b
	Very seldom	c
24 Have you ever suggested that a child psychiatrist be consulted ?	Yes	a
	No	b
25 Do you ever contact the child's own school when he is in hospital ?	Yes	a
	No	b
26 If Yes to question 25 , Usually how long will the child be expected to stay in hospital for you to make the contact ?	More than 1 day	a
	More than 1 week	b
	More than 2 weeks	c
27 Circle the following if you undertake them sometimes.	Cookery	a
	Science	b
	Drama	c
28 If you were planning a training course for teachers entering hospital teaching in what order of priority would you put the following ? Number 1 - 10	Curriculum subjects	
	Art and Craft	
	Hospital visits	
	Children's diseases	
	Child Psychology (Related to illness)	
	Remedial Teaching	
	Social Skills Strategy	
	Counselling Children	
	Use of electronic aids in teaching	
29 State any courses which might help you ?		
30 Are you married or single ?	Married	a
	Single	b
31 What is your age group ?	Under 25	a
	25 -34	b
	35 -44	c
	Over 44	d

Subjects for discussion Date

1. Storage of equipment and teaching venue.
2. Bedside or group teaching. Who is not taught? Start time.
3. Remedial teaching. Maths teaching.
4. Strategy with parents or visitors.
5. Counselling or parenting role. Rewards in teaching.
6. Frustrations of difficulties in planning teaching.
7. Management of interruptions. Personal authority.
8. Information about children. How obtained. Ward Meeting.
9. Ward sister relations. Nurse support.
10. Playleaders role in schooltime.
11. Attitude to play in school and hospital play.
12. Work on hospital environment. Projects. Magazine.
13. 'O level' subjects. Qualifications, special training.
14. Contact with local schools. Outside visits.

Notes

1. Married.
2. Children.
3. Part-time/Full-time.
4. No. of teachers in hospital.
5. No. of hospitals employed.

Appendix 3

CODING CARD

W	WORK (Includes purposeful activity such as letter writing, drawing, watching schools t.v.)
Wg.	WORKGAME (Puzzles, Scrabble, Spelling and Number Games)
G	GAMES OR PLAY (Lego, Darts, Board Games and active games such as tricycling or playing cars)
L	LEAVES WARD
La	LOOKING AT COMICS
T.V.	WATCHING T.V. other than schools programmes
MED	DRESSINGS, X-RAYS, TREATMENT
B	BATHING
E	EATING
WAI	WAITING OR WATCHING
R	READING (Rp for puzzle books)
SL	SLEEPING
CRU	CRUISING (Walking around aimlessly)
CRU(E)	CRUISING (Energetic running around)
DIS	DISTRESSED VISIBLY
CHAT	CHATTING TO parent(p), teacher(t), nurse(n), Playleader(pl)
H	Add H if work or play is hospital orientated

O Teacher Adult Playleader

Code  Teacher  Adult  Playleader

if activity has been organised by one of them.

Play leader

Patients (No)

DATE

OBSERVER

WARD

TEACHER

NUMBER	NAME Entry date	AGE	Med	Mobility	✓/X	ACTIVITY (MORNING) 9.30	9.40	9.50	10.00	10.10	10.20	10.30	10.40	10.50	11.0	11.10	11.20	11.30	11.40
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
11																			
12																			

Playleader

Patients (No.)

12	11	10	9	8	7	6	5	4	3	2	1	NUMBER
												NAME (Entry date)
												AGE
												Med
												Mobility ✓ x
												1.30
												1.40
												1.50
												2.0
												2.10
												2.20
												2.30
												2.40
												2.50
												3.0
												3.10
												3.20
												3.30

ACTIVITY (AFTERNOON)

TEACHER WARD DATE OBSERVER